HIV, AIDS and Integrated Development Planning: A Reality Check

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CONTENTS

LIST OF ACRONYMS

Acquired Immune Deficiency Syndrome	AIDS
Anti-Retroviral Treatment	ART
Community Based Organisation	CBO
Consumer Price Index	CPI
Gross Domestic Product	GDP
Human Immunodeficiency Virus	HIV
Integrated Development Plan	IDP
Land Development Objectives	LDO
Non Governmental Organisation	NGO
Prevention of Mother To Child Transmission	PMTCT
Reconstruction and Development Programme	RDP
Tuberculosis	TB
Voluntary Counselling and Testing	VCT

1. INTRODUCTION

South Africa has been slow to react to the HIV and AIDS pandemic which first hovered at its doorstep and, then, rapidly made itself at home among its places and people. During the dramatic transition of the 1990s, HIV and AIDS were relegated to the backbench of the, then, more pressing agenda of socio-economic and political transformation. The pandemic's gradual encroachment over the South African human landscape was almost un-noticed by a people gleefully engaged in the process of reconstruction and development. In 1991, Chris Hani expressed the view that, although HIV and AIDS may be regarded by some ANC and Mass Democratic Movement members as "a diversion from the important task of transfer of power to the people", "We cannot afford to allow the AIDS epidemic to ruin the realisation of our dream" (Marais, 2000: 4). His call was not heeded. In 1990, the estimated prevalence rate stood at less than 1% across the whole population (Ibid.) By the end of the year 2000, "an estimated 4.7 million adults and children in South Africa were living with HIV and AIDS, more than in any other country in the world" (Centre for Health System and Development, 2002: 20).

It was not until the latter part of the 1990s that the silent killer began hitting home, among South Africa's people and its leaders. Government's response to the pandemic unfolded at first timidly and then frankly as a matter for political contestation and polemic. Presidential and cabinet dissident stances on the matter have received their fair share of media scrutiny, at home and abroad. Contained within the ambit of epidemiological and health care foci, political debates at the top blinded themselves to the impending social and economic catastrophe brewing at the bottom.

While the debates and uproar unfurled on the national stage of policy- and strategy- making, the local landscapes of HIV and AIDS began revealing their gruesome face. Histories of individuals, households and communities devastated by the impact of the pandemic slowly emerged across the country. The role of non-governmental and community-based organisations in publicising the human face of the multi-dimensional impact of HIV and AIDS "at the grass-roots" was certainly significant, as well as their role in mobilising communities to confront the national decision-making spheres. From constitutional court cases to civil disobedience marches and other forms of protest, popular engagement with national policy and strategy has grown in leaps and bounds. Still, the battleground remains one where health sector policy matters appear to prevail. The debates remain focused on access to medical treatment, as opposed to addressing the underlying socio-economic factors that heighten susceptibility to HIV infection and vulnerability to the variegated impacts of AIDS in the South African context.

In late 2003, the government announced a plan to roll out anti-retroviral treatment (ART) universally. Moving from a blueprint to large-scale implementation does not occur overnight. The spread of the pandemic and its multi-dimensional impacts are unlikely to be dealt with for some time to come. Much damage has already been done and much more is yet to come, even with the rolling out of ART. In the absence of a cure, reliance on resource intensive ART as a means to circumvent AIDS morbidity and mortality could prove short-sighted.

HIV and AIDS have, to date, been considered as a problem that relates to and should primarily be addressed by national, and at best, provincial health departments. Yet, the primary impacts of the pandemic are being felt at the local level, by households and communities whose relationships to governmental and non-governmental development agencies are experienced at the local/municipal level. The impacts have been shown to extend well beyond the realm of the health sector; it affects the livelihoods of households and levels of development of communities. In fact, HIV and AIDS have emerged as one of the foremost challenges to poverty alleviation and development.

Municipal role-players and stakeholders, in the practice of their statutory functions and competencies, have a direct impact on the living conditions of the very households and communities who are experiencing the brunt of the socio-economic impact of the pandemic. The Systems Act of 2001 provides that municipalities must develop an Integrated Development Plan (IDP). The IDP is the primary instrument for municipal planning and development. However, few municipalities have effectively used this opportunity to guide local-level development and delivery in a way which appropriately addresses the multi-dimensional impact of HIV and AIDS on their constituencies and on themselves as institutions of governance and service delivery.

1.1 Research method and approach

However limited, research and government interventions with respect to the relationship between local governance and HIV and AIDS have, thus far, focused on the role local government could play in combating the spread and impact of the pandemic. This perspective is HIV- and AIDS-centric. In other words its focus is on the pandemic and it views municipalities only as a means to achieve HIV- and AIDS-related ends. In contrast, this paper is forthrightly municipal governance-centric. It enquires how developmental local governance operates in a context of HIV and AIDS prevalence.

The research was exploratory in nature. It investigated and documented the manner in which selected municipalities, in their IDPs, define, interpret and respond to the local impact of HIV and AIDS. This meant that the research was primarily desk-based and involved careful scrutiny of the IDP documents of selected municipalities. This focus is limiting, in as much as the scope of findings is confined to how well the information generated and decisions made as part of the IDP process were documented. However, as will be explored below, the IDP document is punted as the primary instrument for guiding and supporting investment decisions of municipal and other stakeholders and role-players (Feldman and Ambert, 2003). This means that investment decisions will increasingly be based on the planning document alone. The challenger was to craft a set of questions which could support the scrutiny of each IDP. These research questions were initially developed as a guide to navigate at times extremely lengthy IDP documents (generally in excess of 200 pages). They enabled the identification of relevant information and informed the assessment of municipal interpretation and responses to HIV and AIDS issues. Questions included:

- Which municipalities address HIV and AIDS as part of their current reality analysis? If they do, what particular aspects of the pandemic do they explore?
- Do the municipalities that address HIV and AIDS in their current reality analysis identify it as a priority issue?
- If so, with regard to what category(ies) of impact do these municipalities specify HIV and AIDS as a priority issue?
- Are there gaps between the current reality analysis and the selected priority issues related to specific impact categories? If so, what are they?
- What are the objectives, strategies, projects as well as operational programmes and sector plans that the respective municipalities have formulated in respect HIV and AIDS priority issues?
- In which category of responses do those fall (e.g. prevention, treatment and care, socio-economic impact mitigation, workplace, etc…)?
- Is there consistency between the nature of the impact categories identified in the priority issues and the categories of responses developed? If not what are the key gaps?
- When municipalities have identified HIV and AIDS as a priority issue, have they consistently considered their ramifications throughout the various components of their municipal plan (such as their financial strategies, spatial development frameworks, integrated infrastructure investment plans, etc…), or conversely maintained it as a separate element in the IDP HIV/AIDS programme?
- Is there evidence that HIV and AIDS have been identified as an issue for horizontal and vertical alignment? If so for what category of impact? Are there gaps or conflicts between the strategies, projects and programmes adopted? If so, what are they?

A round table was convened in October 2003 at the French Institute of South Africa to verify debate and augment the findings of this desk-top analysis of selected IDPs. Participants in the round table included representatives of local government (including some of the municipalities whose IDPs were considered as part of the research), research and academic institutions, donor and international agencies. The background of these institutions ranges from focusing on HIV and AIDS and development to focusing on development and local governance issues.

1.2. Selection of municipalities

A focus on IDPs meant that the criteria used for the selection of municipalities had to ensure diversity of municipal profiles. In other words, criteria such as the prevalence and incidence of HIV and AIDS were secondary to ensuring that the municipal contexts in which the IDPs were developed were representative of a broad range of profiles. The following factors were taken into consideration:

- **District, metropolitan and local municipalities:** The different categories of municipalities have different powers and functions. These have been assigned through statute and ministerial decree, and are therefore not always uniform across the country. These powers and functions could accordingly have a critical bearing on the particular governance lens through which different categories of municipalities view HIV and AIDS.
- **Newly established municipalities:** The re-demarcation process which was undertaken throughout the country in 2000 has led to the creation of new municipalities. These have either incorporated pre-existing entities or been set up afresh. In the latter situation, they have often not yet achieved to recruit the human resources which they require to operate as i they should and may only have a limited staff complement. Therefore, their current institutional capacity may not be adequate to consider or respond to the multi-dimensional impact of HIV and AIDS within the ambit of a cross-sectoral municipal plan.
- **Geo-political differences:** In some provinces, municipalities include former homeland, self-governing territory administrations, former Republic of South Africa town councils and regional services councils or a combination. This diversity has a bearing on the socio-economic and settlement profiles of the population as well as on access to services.

The municipalities selected according to these criteria were:

- The West Rand District Municipality inclusive of its local municipalities. These municipalities are primarily urban, and located in the wealthiest province in the country, Gauteng, and are historically mining centres.

- Ethekwini Metropolitan Municipality. This coastal metropolitan municipality is located in the KwaZulu Natal province. It includes diverse settlements that range from rural areas over which traditional authorities wield some authority, to dense peri-urban and urban settlements .
- Ehlanzeni District Municipality inclusive of its local municipalities. These are primarily rural and peri-urban, save for the historical centre of Nelspruit. The district area of jurisdiction includes both former homeland and former Republic of South Africa territories.

Each municipality was contacted to gain access to the IDPs. The planning department of the municipalities or the PIMS officials made available electronic copies of the IDPs. All municipal councils were meant to have adopted a reviewed IDP by the end of April 2003. At the time when access to the IDPs was gained, not all municipalities had completed the review process. As a result, some of the IDPs accessed for the research are not reviewed IDPs. The table below provides an overview of the status of the IDPs which this research has focused on.

Municipality	Adopted IDP 2002	Adopted reviewed IDP 2003
Ethekwini		X
Ehlanzeni District Council		X
Mbombela		X
Nkomasi		X
Thaba Chewu		X
Umjindi		X
West Rand District Council	X	
Mogale City	X	
Merafong	X	
Randfontein		X
Westorania	X	

1.3. Structure of the paper

This paper consists of three main sections, aside from this introduction:

- Section 2 explores the rationale for the research by demonstrating why municipalities should be concerned with HIV and AIDS in their IDPs;
- Section 3 presents the findings of the research, namely how the IDPs interpret and respond to HIV and AIDS impacts;
- Section 4 draws conclusions from the research findings in order to inform the formulation of potential support strategies.

2. ENGAGING WITH IDPs AS A MEANS TO CAPTURE LOCAL GOVERNMENT RESPONSES

On the surface, there is little municipalities and in particular IDPs can do about HIV and AIDS. It could be argued that, as a disease, HIV and AIDS are matters that are best left to the medical profession and, from a governance perspective, to health authorities. Below the surface, however, HIV and AIDS conditions are dramatically affected by (and in turn impact) the socio-economic fabric of households and communities over which the municipality has jurisdiction. The following section provides a rationale for the research and sets out its theoretical parameters by examining why IDPs should concern themselves with HIV and AIDS, by exploring how:

- The constitution entrenches local development as the concern of developmental local governance;
- IDP has been introduced as a central instrument for developmental local governance and guiding alignment between the planning and implementation of the sectors and spheres of government;
- HIV and AIDS impact local development circumstances from a macro-level perspective and have implications for local governance;
- HIV and AIDS affect infected individuals and non-infected, households and communities has a substantial bearing on local development circumstances and thus implications for local governance;
- HIV and AIDS impact the municipality as an employer and service provider.

2.1. Local development as the concern of local governance

Municipalities are components of an overall system of governance, and have been institutionalised as such. The South African Constitution provides for the establishment of three spheres (rather than tiers) of government, each responsible for specific functions within specific sectors. This means that, although each sphere has jurisdiction over its attributed sectors, it must perform the associated powers and functions in such a way as to co-operate and co-ordinate with the other spheres concerned. The Constitution is the first port of call in terms of assessing which sphere is responsible for what function.

Section 152 (1) of the 1996 Constitution sets out the purpose of local government as the provision of democratic and accountable government for local authorities. This includes the provision of services to communities in a sustainable manner, the promotion of social and economic development within a safe and healthy environment, where communities and their organisations are involved in the matters of local government. Further, the developmental duties of local government are spelt out in Section 153 of the Constitution as requiring a municipality to structure and manage its administration, and budgeting and planning processes to give priority to the basic needs of the community, and to promote the social and economic development of the community. As will be explored in detail in the subsequent sections of this article, all of the above are development matters that are directly vulnerable to through their IDPs HIV and AIDS micro and macro levels.

Section 156 (1) of the Constitution states that the powers and functions of municipalities are (a) the local government matters listed in Part B of Schedule 4 and Part B of Schedule 5; and (b) any other matter assigned to it by national or provincial legislation. The Constitution makes provision for a municipality to administer a matter listed in Part A of Schedule 4 and 5, if that matter would be most effectively administered locally, provided the municipality has the capacity to administer it (Section 156, a and b). These include, among others, municipal planning, environmental health, land use management and water and sanitation services. Again, within a constitutional framework, local government is responsible for matters that are directly related to local development concerns. As will be explored in greater detail further, local development is particularly vulnerable to HIV and AIDS impacts. In turn, it is clear that, to perform its specific governance roles, the municipal sphere will confront the impacts of HIV and AIDS and thus will need to factor them into its developmental role.

2.2. IDP as the instrument for developmental local governance

Having established the framework for considering the linkages between local governance and HIV and AIDS impacts on local development, we now turn to the Integrated Development Planning (IDP) process and its status as a key instrument for local government to take up the challenge presented by HIV and AIDS impacts on local development and in turn on local governance. The IDP process for local government was introduced as a policy-driven approach and method to achieve co-ordination and integration between a variety of actors and interests to set strategic priorities and specify how to deliver on them.

The seed of integrated development planning for local government was planted into the South African governance ground, with the Development Facilitation Act of 1995. IDPs as planning instruments were introduced in 1996 with the Local Government Transition Second Amendment Act, and specified as tools of developmental local government in 1998 with the Local Government White Paper. The 2000 Municipal Systems Act announced the mainstreaming of IDP as part of the overall mandate and operations of municipal government, and specified the method, outputs and status of the process.

The Development Facilitation Act of 1995 introduced the Land Development Objectives as a future-planning instrument. LDOs consisted of objectives, strategies and quantum of targets for delivery across all sectors of development, in particular in respect of land release for housing and settlement development. The Local Government Transition Act took the requirements of the Act further and required each local authority to draw up an IDP.

The White Paper on Local Government presents the new policy approach to ensure that all citizens have access to minimum basic services, to promote democracy and human rights and to promote economic development through 'developmental local government'. The White Paper urges local government to focus on realising developmental outcomes, such as the creation of liveable, integrated cities, towns and rural areas, and the promotion of local economic development and community empowerment and redistribution. Again, while the White Paper clarified what was expected in terms of the process and outputs of IDPs, it remained fairly unspecific.

The Municipal Systems Act gives effect to the country's vision of 'developmental local government' as envisaged in the Local Government White Paper. Building on the Constitution's provisions for basic human rights, co-operative governance and developmental objectives of local government, the Act elaborates the core principles and mechanisms that are necessary to enable municipalities to move progressively towards the social and economic upliftment of communities, and ensure universal access to services. The Act establishes a clear framework for the core processes of planning, performance management, resource mobilisation and organisational change, which underpin the notion of developmental local government. By co-ordinating these processes into an integrated cycle at the local level, the Act undoes the complex, fragmented and top-down approaches of the past.

Chapter 5 of the Act deals specifically with Integrated Development Planning and clarifies municipal planning in co-operative governance; the contents of the Integrated Development Plans; the process for planning and adopting IDPs; and the legal consequences of adopted IDPs.

The Municipal Systems Act 32 of 2000, chapter 2, section 2, sub-section 1 establishes that an IDP must at least identify:

a) The institutional framework that addresses:
   i) the implementation of the integrated development plan,
   ii) the municipality's internal transformation;
b) Any investment initiatives in the municipality;
c) Any development initiatives in the municipality including infrastructure, physical, social and economic development as well as institutional development;
d) All known projects, plans and programmes to be implemented within the municipality by any organ of the state;
e) Key performance indicators set by the municipality.

Regulations to the Act specify that the contents of the IDP should include a financial plan as well as a spatial development framework.

Section C of the White Paper on local government notes that it is increasingly seen as a point of integration and co-ordination, vertically and horizontally. IDPs are intended to be the planning instrument of this integration and co-ordination between the different spheres of government. In particular, the IDP is supposed to cover sectors over which municipalities do not have competency to ensure that their plans and delivery processes complement those of municipal government.

There are at least six other national sector departments, besides the Department of Provincial and Local Government, which require municipal planning to be undertaken to inform their programmes and budgets. These requirements vary in nature and status. Some are legal requirements for the formulation of a discrete sector plan, like Integrated Transport Plans, Water Services Development Plans, Waste Management Plans and Environmental Management Plans. These specific plans have an important bearing on municipal access to sector finance as they are often linked to the resourcing of municipal project finance from national sector programmes. Others are legal compliance requirements with normative principles of sector legislation. A third category is a requirement that planning be undertaken as a component of the IDP, like housing strategy planning, disaster management planning and spatial development planning.

A further type of requirement is more a value adding recommendation, than a requirement, like Local Agenda 21. Historically, sector requirements have placed a costly burden on municipalities to fulfil them. In municipal contexts with limited planning capacity, these sector requirements pitted themselves in competition against the IDP for the attention and dedication of officials and politicians. In the course of 2000, a process of negotiation was undertaken with the respective national sector departments to assist in clarifying and rationalising the municipal planning requirements. It was agreed that IDPs should be the spine of the municipal planning process, while the sector requirements should be incorporated into it where appropriate, or undertaken in a parallel but aligned fashion.

The potential relationships between HIV and AIDS impacts and sectors are explored below. At this stage, it is important to highlight that HIV and AIDS may impact on sectors over which municipalities have a competency or interest and specifically a planning role. Given the centrality of the IDP "spine" for alignment between both the planning and implementation by the sectors and spheres, it is arguable that addressing HIV and AIDS impacts on the sectors over which municipalities have competency should take place within the IDP framework. The following section explores the various dimensions of the impacts of HIV and AIDS on local development .

2.3 . Setting the scene: HIV and AIDS impacts on local development

In South Africa, there is no certainty about how the epidemic is spreading. No reliable data is available on AIDS cases and related deaths. The HIV epidemic in South Africa is likely to remain hidden for a long time, both in statistics and to the public, as the full force of the AIDS epidemic, which lags behind the HIV epidemic, has yet to be experienced (ABT, 2002). However, HIV infection is concentrated in people of working age, and the scale and nature of the epidemic in South Africa make it a significant factor to consider in all sectors.

Just as viruses do not hold back in front of international, provincial or municipal boundaries, so can macro-level social and economic trends affect local circumstances. In the following section, HIV and AIDS impacts on local development are explored at the macro level, in terms of demographic forecasts and then by considering how the pandemic can affect economic development.

2.3.1. Macro-level impacts and implications for local governance

Infection rates among women frequenting ante-natal clinics are used as a proxy for estimating national and provincial prevalence. In the results of the ante-natal survey published in March 2001 (Kaiser Daily Health News in Centre For the Study of AIDS, 2002), point prevalence rates for HIV infection in the nine provinces for the year 2000 were estimated as highest in KwaZulu-Natal (KZN) 36.2%, Mpumalanga (MP) 29.7%, Gauteng (GP) 29.4% and Free State (FS) 27.9%; and lowest in North West (NW) 22.9%, Eastern Cape (EC) 20.2%, Northern Province (NP)(13.2%, Northern Cape (NC) 11.2% and Western Cape (WC) 8.7% (Ibid.). The disparities in the provincial infection rates are narrowing and, with the exception of the Western Cape, the gaps between the provinces are closing. There are also strong indications that HIV impacts can differ markedly across communities within any region. Population-based studies highlight the potential differences in HIV prevalence between different communities even within local areas (ABT, 2002). Information on the urban-rural distribution of HIV infection in South Africa has not been published and raw data from antenatal surveys has not been made available for analysis. However, where prevalence in rural areas is relatively low, it may often indicate a delay in development of their epidemics, rather than a fundamentally different risk profile from urban areas.

In 2001, the national average was estimated at 24.5% (Centre for the Study of AIDS, 2002). This means that one in nine South Africans is currently estimated to be living with HIV, up from one in ten in the previous survey. 4.7 million South Africans are estimated to be living with HIV up from 4.2 million at the end of 2000. Difference between projected total population in 2000 and 2010, according to different actuarial models exist. Figure 1, below, provides an overview of the projected population up to 2015, by differentiating between a no AIDS scenario, in white, a change scenario (i.e. where behavioural and treatment interventions are made), in grey, and a no change scenario, in black. These projections have been compiled by making use of the recently re-calibrated ASSA model, the ASSA 2000 model.

Figure 1: Total Population in South Africa, (ASSA, undated)

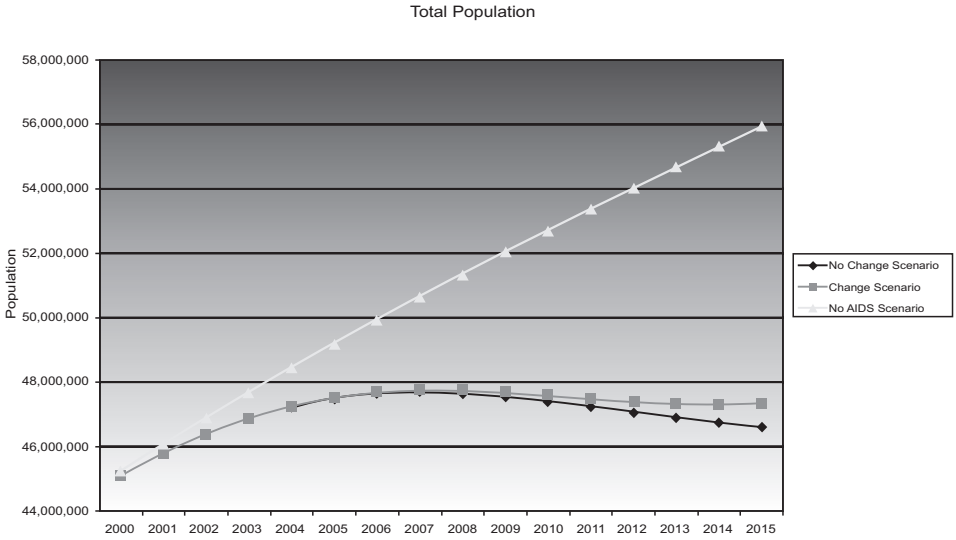


Figure 1 reveals a substantial drop in total population figures. The difference between the no AIDS and the Change and/or No Change trend lines is taken to represent the total population impact. It is worth stressing that the difference, in terms of total population numbers between the Change and No Change scenarios, is minimal in the short term but accentuates from 2010 onwards. In other words, while the introduction of ART minimises to some extent the pandemic in absolute numbers, population growth patterns appear to have been significantly altered.

In Figures 2 and 3 below, population pyramids are captured for 2015, in a no AIDS and AIDS scenario (ASSA, 2000). The two population pyramids show the change in population structure in 2015 that would be due to HIV and AIDS.

Figure 2: Population Pyramid 2015, no AIDS scenario (ASSA, 2000)

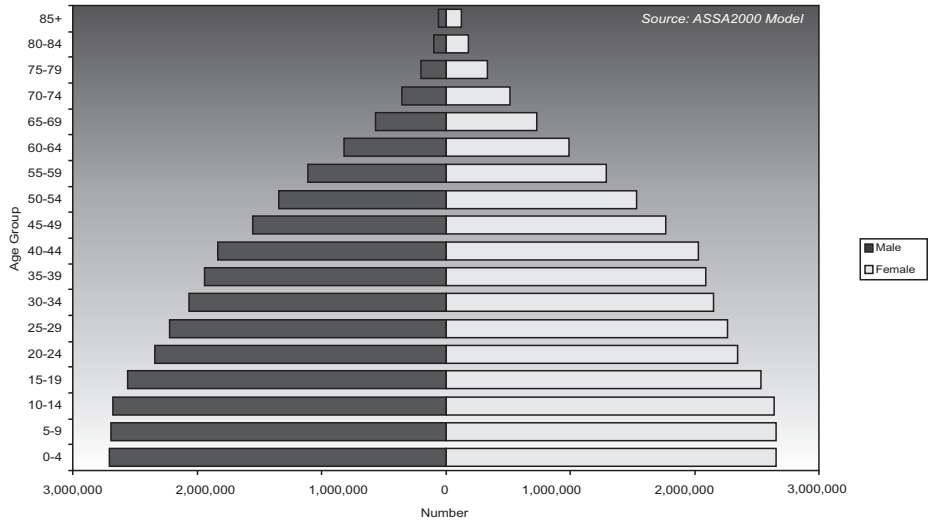
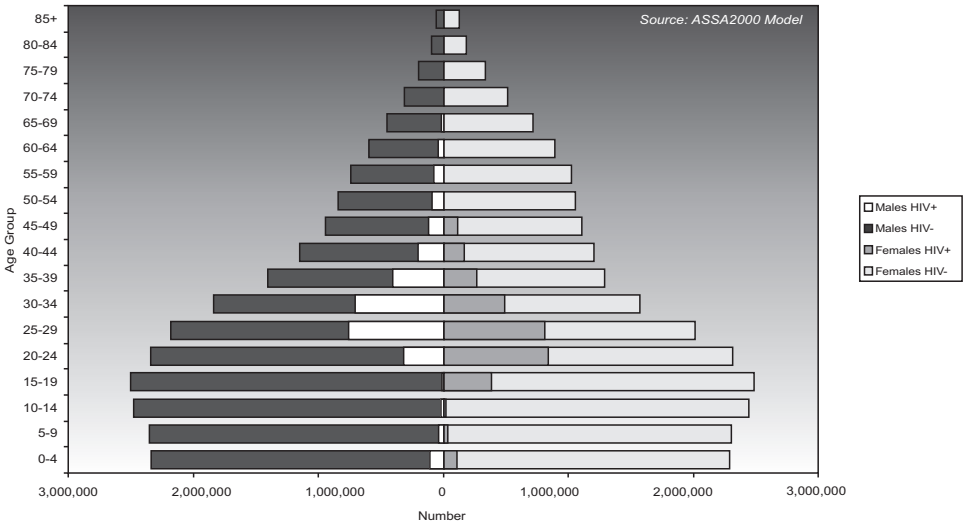


Figure 3: Population pyramid, 2015, no change scenario (ASSA, 2000)



The population pyramid contained in Figure 2 is typical of that of a developing country with its symptomatic broad base. Figure 3 provides a graphic representation of the substantial shifts in population profile in 2015.

There, a few observations can be made. Firstly, the base of the pyramid has shrunk substantially, suggesting an important reduction in the rate of natural population increase, due largely to increasing infant mortality as well as an overall decrease in fertility levels. Secondly, the ratio of male to female population is substantially skewed in favour of males, who are generally much less vulnerable to HIV infections than females. Thirdly, there is a much more pronounced decrease in the proportion of the population aged 25 to 60, indicating a substantial shift in household dependency ratios, and suggesting a substantial rise in the number of orphans and young adults without one or two parents. For example, in 2002, the national number of AIDS orphans was 279,102 (CSA, 2002). This figure will increase substantially by 2015, arguably beyond the carrying capacity of social networks that have historically provided care and guardianship support to orphans. This is already and will continue to give rise to household profiles that differ from the current ones. These household profiles may have substantially different abilities to engage with the municipal sphere as a provider of services and local governance systems. For instance, child-headed households are unlikely to engage effectively with municipal procedures and requirements.

HIV and AIDS affect the macro-economy and in turn the allocation of nationally generated revenue to the municipal sphere

Another perspective on HIV and AIDS impacts may be framed by considering the macro-economic impacts of HIV and AIDS, and how these would relate to the overall role of municipal governance. While macro-economic impact research processes have, to date, agreed to foresee a profound impact on the country's economic outlook, the exact nature and extent of projected impacts vary. The basic assumptions of these modelling exercises are that the epidemic impacts the economy as follows:

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur among workers in their most productive years. As younger, less experienced workers replace these experienced workers, work productivity declines.
- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages. CPI inflation will pick up due to cost pressures on companies that are passed on.
- The cost of the epidemic is likely to cause a domestic savings squeeze.
- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.
- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time (Futures Group International, 1999).

The first model developed to produce reliable estimates of the progression of HIV and AIDS in South Africa was the Metropolitan-Doyle model formulated in 1988. It has since been reviewed, and followed by other models including the Actuarial Society of South Africa Model. Most models are based on some form of projection of the impact of the HIV and AIDS pandemic on the population differential and apply the findings to macro-economic inputs and output projections based on specific economic linkages by reviewing demographic impacts on growth scenarios. The non-alarmist scenario forecasts of ING Barring (2000) predict that GDP growth is forecast to be on average 0.3-0.4 percentage points per annum lower than on a no AIDS baseline. In their 1997-2010 impact simulation exercise, Arndt and Lewis (2000) find that GDP levels could be 17 percent lower in an AIDS scenario.

HIV and AIDS impacts undermine the fiscal viability of the municipal sphere

Irrespective of the full scale of the impact of HIV and AIDS on the macro-economy, it is clear that its outcome may be such that the total income per capita and total consumption per capita can decrease dramatically. Tomlinson et al (2003) suggest that, in a context of globalisation where formal employment is on the decrease in South Africa, HIV and AIDS will compound existing pauperisation trends. This may well mean that, both at the bottom and at the top, spending priorities will go towards fending off increasing socio-economic vulnerability. At the bottom, decreasing per capita incomes may result in situations where, households that would otherwise not be eligible for state assistance, that affect municipalities, become eligible (from an income threshold perspective alone) because of the macro-economic impacts of HIV and AIDS. At a macro-level, this situation could overwhelm already fragile municipal fiscal sustainability capacities on an unprecedented scale and thus require much greater levels of nationally generated revenue allocation to the municipal sphere. Alternatively, this could result in situations where substantial resources, previously allocated for settlement development and municipal management, are re-allocated to fund public health and welfare departments and agencies. Typically, these operators are associated with the provincial sphere of government, thus suggesting that the allocation of nationally generated revenue to the municipal sphere could be proportionally reduced.

Of particular relevance to the municipal sphere of government is the impact which HIV and AIDS will have on the number of households and their economic capacities. Indeed, municipalities are affected by household patterns, not only for the coverage of bulk and connector infrastructure required, but also for the resources at their disposal to implement as well as operate and maintain such infrastructure. Importantly, the macro-demographic impacts of HIV and AIDS are occurring in a context of substantial social transformation. Recent analyses of the latest census projections have identified the emergence of new household demographic trends. Among those, the doubling of household number, in the period between 1996 and 2001, disproportionately to the increase in total population numbers has been interpreted by some as being plausibly related to HIV and AIDS impacts, although no conclusive interpretation has been made in this regard (Tomlinson, R et al., 2003). While there may be a range of reasons for household decompression (whether HIV- and AIDS-related on not), this trend has wide-ranging implications for the municipal sphere. First, it implies that the historic household numbers which have been used to calculate backlog figures for service delivery will need to be revised. At a global summit on public-private partnerships held in Cape Town, Minister Mufamadi was quoted as quantifying the cost of providing a basic level of services to all South Africans as R38.5bn, and the borrowing cost to provide full services as R30.1bn (Thomas, R et al., 2001). An increase in household number suggests the need for a revision of the investment level required. Importantly, while municipalities can draw on conditional subsidy transfers from national government to cover some of the cost of capital infrastructure investment; this is only a partial contribution to the required investment level. Municipalities are the recipient of an intergovernmental transfer to cover the operational and maintenance costs of providing basic services to indigent households, through the equitable share. The allocation to each municipality is calculated on the basis on the number of indigent households within the municipality's area of jurisdiction. On the surface, this would suggest that household decompression, whether brought about by HIV and AIDS or not, signals a fiscal boon for the municipal sphere. It is, however, important to note that current allocation levels are deemed to be highly inadequate to sustain actual costs per households. In a context heavily impacted by HIV and AIDS, it is likely that the number of households eligible for indigence support measures from the municipal authorities will outstrip both the current allocation levels for the short and medium term, and the municipalities' own contribution to the cost of municipal services and local governance systems.

Contemplating impacts in macro-demographic and macro-economic terms only would be highly insufficient. Indeed, the demographic impacts of HIV and AIDS induce far greater transformation. A closer consideration of the range of individual as well as household level- impacts is required. To explore these dimensions, the next section of this article draws on recent literature documenting empirical research undertaken through key studies:

- "The impact of HIV/AIDS on the demand for low cost housing" undertaken by Khayamandi (2002), which surveyed a total sample of 2935 respondents frequenting HIV/AIDS support groups and clinics;
- "The Socio-Economic Impact of HIV/AIDS on Households in South Africa: Pilot Study in Welkom and Qwaqwa, Free State Province", by Booysen, F. le R., Bachmann, M., Van Rensburg, H.C.J., Engelbrecht, M., Steyn, F. and Meyer, K. (2002) comparing socio-economic changes between 406 HIV/AIDS affected and non-affected households;
- "The impact of HIV/AIDS on land issues in KwaZulu-Natal province, South Africa", by Cross, C. (2002) documenting and analysing detailed case histories of 20 HIV/AIDS affected households;
- "Hitting home: how households cope with the impact of the HIV/AIDS epidemic", by the Health Systems Trust (2002) documenting and analysing the findings of a survey of close to 800 HIV/AIDS affected households;
- "Impact of HIV/AIDS on the construction sector and in turn on the implementation of the Housing Policy", Development Works (2002) documenting the findings of in-depth primary and secondary research on the impacts of the range of delivery agents active and supply systems through which the Housing Policy is implemented;
- Draft report, "Impact of HIV/AIDS on local government - With specific consideration of Inca's sphere of business", by Thomas, L; Crewe, M; Walker, L; van der Heever, A; Bleibaum, U and Marx, C. (2001) exploring potential impacts of HIV and AIDS issues on local government;
- "Background paper: The interface between HIV/AIDS and urban land issues", by Development Works (2003) submitted to the Urban Sector Network for DFID SA.

2.3.2. The micro-level impacts of HIV and AIDS and implications for local governance

The following section examines the micro-level impacts of HIV and AIDS and their implications for local governance[1]. It unpacks the various dimensions of these impacts by first focusing on infected individuals in terms of morbidity and mortality matters. Second, it moves to the impact of the pandemic on household livelihood opportunities, and finally community-level impacts. This analysis does not aim to be exhaustive but to point to key areas of potential interface between the micro-level impacts of HIV and AIDS and their implications for local governance. Again, while some attention is given to the pandemic from a health sector perspective, the dominant tone seeks to position a consideration of HIV and AIDS matters from a local development perspective.

Focusing on the individual, HIV and AIDS morbidity and mortality

HIV/AIDS is a chronic disease. Most infected people only show signs and symptoms of disease after many years, leaving the extent and impact of the epidemic hidden. The average time from HIV infection to testing HIV positive is 2 months (the so-called "window period"). The average time from contracting the virus to the onset of AIDS is 10 years (Abt, 2002). Average survival following an AIDS defining condition is 2 to 3 years without anti-retroviral treatment. HIV infection results in a progressive weakening of the immune system. This makes a person susceptible to a wide variety of opportunistic infections and cancers. Secondary infections due to lower immunity occur at stages of disease before development of AIDS itself. Secondary diseases that are termed "AIDS defining conditions" occur in the end stage of the natural history. Diseases associated with HIV infection include tuberculosis, diarrhoeal diseases and pneumonias (Ibid). These physiological changes, ultimately resulting in the death of the HIV/AIDS victim, have direct requirements and implications from the manner in which land is held and transacted. The following section focuses on land dimensions in as much as they relate directly to HIV infected individuals (opposed to households which are considered in subsequent sections). This section raises issues relating to the physiological requirements from municipal governance in relation to access to health and other services as well as shelter requirements. It then considers impacts in terms of migration. Burial practices and their implications are considered last.

[1] This section draws extensively from a Development Works background paper contribution to the USN and, in turn, DFID SA, pertaining to the interface between HIV and AIDS and urban land issues.

HIV and AIDS morbidity have a bearing on spatial and transport planning

The health care support requirements of HIV-infected individuals increase progressively and become more complex with the onset of AIDS defining conditions. In the Booysen study, it was found that government health services were the most common providers of health care. Ill members of affected households in most cases attended a government clinic and in some cases a government hospital, while ill members of non-affected households were most likely to have attended a government clinic. Similarly, the Khayamandi research showed the significance of access to government hospital as a preferred source of care over other options. It is worth noting that the current health care dispensation in respect of the treatment of HIV and AIDS victims is promoting home-based care as a substantial source of care. Importantly, this option has not been consistently applied in all provinces or municipalities. Further, the emphasis on deconcentrated primary health care through the establishment of community clinics and related services means that the spatial accessibility of the preferred source of service (government hospitals), will be challenging for a substantial majority. This suggests that the continued peripheralisation of access to the urban core (through both formal and informal delivery channels) appear particularly at odds with the health-care requirements and preferences of HIV and AIDS victims. It is important to note that, while municipalities will come to play a decreasing role in respect of the provision of health care services, they play a substantial role in planning for public transportation services, and the physical accessibility of health care facilities.

HIV and AIDS morbidity has particular requirements from water and sanitation services

In the case of water and sanitation services, (Tomlinson, R et al, 2003) note that if the infected person and their households cannot wash easily and do not have access to hygienic sanitation, there is greater risk of diarrhoeal organisms and skin infections. They also argue that clean water is also necessary if mothers with HIV or AIDS are to be able to bottle feed their children, and that it improves the efficiency of home-based care workers who can visit more patients allegedly up to twice as many. Finally, they suggest that the absence of adequate water and sanitation is reported to cause families to entrust ill family members to institutions. This consideration is particularly important from a local governance perspective as municipalities play a decisive role in setting not only service standards but also tariffs.

HIV and AIDS introduce new migration patterns

Migration of infected individuals was noted in both the Khayamandi and Booysen research. In the Khayamandi research, the main reasons for individual as opposed to household mobility were reported as linked to the desire to leave the family, for privacy and independence, and to get care and support. Discrimination against HIV positive persons accounted for 8.10% of the HIV positive persons migrating. This low percentage should however be considered against the fact that only 8.1% of those that are HIV positive told their neighbours, and that only 20.7% told their friends. In the Booysen longitudinal research, 14 out of 406 households could not be interviewed due to reasons related to migration. In affected households more than a third of persons moved because of relatively uncommon reasons, i.e. to stay with parents, other family or friends, or because of illness or death. The migratory patterns of HIV- and AIDS-affected individuals were characterised in both pieces of research as atypical to the migration patterns of non-affected households and individuals.

The locational needs of HIV and AIDS victims have received some research and policy consideration from a minority of provincial organisations. In the Khayamandi research, a large proportion of respondents indicated closeness to health centres as the most important locational factor. This was followed by 18.6% of respondents across the spectrum of settlement context stating they would prefer to move to urban areas and 9.4% close to where they live currently. On the other hand, on the basis of her interaction with HIV and AIDS support groups and NGOs, Liz Floyd, HIV and AIDS co-ordinator for the Gauteng province, suggests that as a result of awareness raising activities in the province, the level of stigma associated with the disease has substantially decreased (Floyd, Presentation to the DBSA, June 2002). In turn, this has meant that HIV infected individuals are less wary of disclosing their status to their neighbours and friends than would otherwise be the case, or of remaining within their communities and household even through the last stages of the illness. She further contextualised the trend by emphasising the successful establishment of home-based care systems and support groups throughout the province. Accordingly, this would suggest that where the support environment is established the temporary nature of access to a particular type of shelter (and residential arrangement) may need to be de-emphasised. This diversity of perspectives is not easy to address in the absence of dedicated research findings. It is however plausible to assume that this diversity is context-specific and may call for a range of responses.

Importantly, whilst it is worth noting that, historically, policy responses to migration have been at worst particularly repressive and at best unaccommodating, and articulated at the national level, there is no indication that the HIV and AIDS implications for individual mobility are now being considered, either nationally or locally. Instead, much of the current municipal sphere's response to one of the outcomes of migration in a context of insufficient housing in urban contexts, informal settlement processes, has also been particularly repressive.

AIDS mortality increases the demand for burial services

Disposing of the bodily remains of AIDS victims is an issue which government role-players, in particular municipalities, whose sphere has competency not only over cemeteries but also environmental health, are attempting to grapple with. N. Botha, Deputy Minister, Provincial and Local Government, mentioned, in a speech given at a symposium on local government and HIV/AIDS, the increasing demand for land for cemeteries and incidence of pauper burials and poverty-relief programmes as particularly challenging to municipalities. Harber (2002) depicts the horror of cemeteries as freshly ploughed fields, over-spilling into public open spaces and roadways and the abandonment of cadavers for pauper's burials. He forecasts that in five years' time South Africa will require 65 ha of land each month to bury the additional bodies of HIV and AIDS victims in both formal and informal burial grounds which will sterilise land. Whilst this issue has been identified, its full scale and implications have yet to be ascertained. Nevertheless, this matter will certainly affect municipalities in a very direct and tangible manner, both in respect of burial and environmental health matters.

2.3.3. Impacts of HIV and AIDS on affected households' and communities' livelihoods

Whiteside and Sunter (2000) posit that AIDS will have a greater livelihood impact than death from other causes. Their suggestions as to why this may be so include; the protracted nature of HIV illness; the lengthy depletion of household resources giving rise to greater and more enduring hardship. They note that not only does poverty help drive the epidemic, but that AIDS increases poverty levels and socio-economic inequality.

The following section unpacks as follows how HIV and AIDS impacts livelihoods, and is based on the findings of documented research :

- The section explores the household economic impacts of the pandemic by considering how HIV and AIDS affects income and expenditure streams and to what extent. It also explores financial coping strategies such as the use of savings, borrowing and asset disposal as well as long-term planning and preparedness;
- Household transformation patterns are considered next in terms of household size, dependency ratios, mobility and organisational capacity;
- Finally, consideration is also given to the broader community and settlement level impacts.

Economic impacts on the household

The economic impact of HIV and AIDS on households is concerned with considering how the pandemic interfaces with household income generation, expenditure and financial strategies (in the short and long-term). These considerations are used to draw some findings in terms of the effects of livelihoods impacts and their implications for local governance.

HIV and AIDS impact on household income generation

The impact of HIV and AIDS on income generation is creeping and systemic. After the onset of AIDS defining conditions, where unavailability of treatment combines with a lack of food security, opportunistic infections together with a decline in productivity levels means that the inability to undertake either formal or informal (or even survivalist) economic activity substantially reduces income streams. It is, however, not only a case of the AIDS victim loosing income opportunities. In the Booysen study, it was found that most households with ill or dying members carried a burden of caring. More than 60% of ill people required someone to care for them at home, while more than half required someone to accompany them to health care. Critically, the Health Systems Trust research noted that although a range of grants (including disability grants) exist that may alleviate a loss of income due to HIV and AIDS morbidity, the take up rate of the grants can be extremely low. As mortality sets in, immediate and extended family members, neighbours and friends are also mobilised to attend funerals and provide support to the bereaved immediate household members. It is important to stress that, in South Africa, the economic impact is being overlaid on a household and community-level economic context which is already weak and where more than 40% of the potentially economically active population is unemployed.

HIV and AIDS impact on household expenditure levels and patterns

Increase in the extent and changes in the patterns of household expenditure are driven by morbidity and mortality. In terms of morbidity, the Khayamandi research found that close to 40% of the HIV positive persons reported that their overall expenditure had increased. Those that indicated an increase in overall expenditure reported the reasons to be increased payments treatments and increased food and medication required. In the comparative Booysen research, it was found that a substantially larger proportion of household resources were allocated to expenses on food and health care, while a smaller share goes to expenditure on education, clothing, personal items, transport and durables. The share of expenditure on housing is more or less similar.

The Booysen study found that death puts a much greater financial burden on a household than does illness. In a worst case scenario, the burden on affected households amounted to 3.4 to 4.3 times average monthly household income and 5.7 to 7.2 times average monthly household expenditure. Unlike in the case of illness, the cost of a death to households remains high even where unemployment levels are very high and household members are primarily cared for by relatives with no direct loss of income. This can be attributed to the fact that funeral costs are very high and represent the largest share of the cost of mortality. The average direct cost of mortality to affected households respectively amounted to R3928 and R5018 per death. The Health Systems Trust research corroborates the scale of the impact of AIDS deaths on household expenditure patterns and noted that rural households spent 350% of total monthly household income on funerals, compared to 500% in urban areas. What is significant about the nature of this expenditure is the sudden drain it places on household resources which have to be mobilised at once and will not be used for any productive purpose (i.e. they are primarily geared to cover funeral costs). Furthermore, in spite of signs of approaching morbidity, the extent to which affected households are able to mobilise resources to cover funeral costs in advance appears limited. The Khayamandi research revealed that few respondents had made arrangements to cover the immediate and longer-term costs associated with their passing. This should perhaps be contextualised in the light of the widespread practice of burial societies, informal savings clubs that pool together their members' resources to cover funeral expenses thereby cushioning the sudden nature of such expenses. It is, however, highly plausible that the savings capacity of such societies is being depleted with the increase in AIDS-related mortality. This confirms the findings of the Booysen research which found that relatively few households that had experienced a recent death received a lump-sum payment or inheritance following the death, underscoring the few means poor households have to cope with death.

Changes in expenditure patterns do not stop after the death of HIV/AIDS cases in the household. The Booysen research found that when comparing regular expenditure patterns in households that have not had to cope with a death and were affected by a death, it was found that households affected by death spend relatively more of their available resources on food, health care, clothing and rent, and less on education, household maintenance, transport, personal items and durables compared to households where no death had occurred in the previous six months. However, in terms of households affected by multiple deaths, changes in expenditure patterns are particularly dramatic, with rent, durables and transport almost falling out of the picture in favour of expenditure on health care, food and other basic needs.

HIV and AIDS impacts are amplified because of inadequate financial coping and future planning strategies

In order to cope with decreasing income and increasing expenditure, households can draw on four types of coping strategies: they can borrow, utilise savings, sell assets, or seek to increase income. The Booysen study found that the most frequent responses of households to financial crises seem to be borrowing, followed by the utilisation of savings and the sale of assets, with a considerably larger proportion of affected households that had utilised these strategies also being affected by illness and/or death. In the total affected and non-affected samples money was borrowed from relatives and friends in almost 70% of cases. The magnitude of dis-saving is considerable as affected households gradually deplete their savings as the costs of morbidity and mortality increase, and at the time of the latest wave of interviews in the longitudinal study had utilised up to 46 months of current savings, whereas non-affected household only utilised 5 months. Moreover, affected households save approximately 40% less than non-affected households on a monthly basis. Only a very small percentage of households sold assets. Affected household that sold an asset were affected by illness and death. The small number of assets owned by the average household explains why only very few households were able or willing to sell. Households primarily sold household appliances, livestock, furniture and vehicles. Proceeds from asset sales represent a very substantial financial coping mechanism and were used to pay for food or to repay debt. The Khayamandi study, confirmed the practices of dis-saving and borrowing but also noted the existing high levels of household debt owed by the households, which amounted on average to 4 times the amount of household income.

The Cross study found that the household labour and asset mobilisation ability of HIV- and AIDS-affected households was minimal and that successfully developing and implementing alternative income generation strategies presented insurmountable challenges to such households. Of note in urban and peri-urban contexts is the widespread practice of informal rental as a means of income generation. Recent media coverage has periodically raised some of the risks associated with weakly structured or headless households unable to maintain a hold over their assets in such situations of informal rental, although there is insufficient empirical evidence documenting this phenomenon.

The above provides some insights into the coping practices for managing (albeit poorly) the household economic impacts of pandemic. These practices are emerging in an ad-hoc manner. The Khayamandi research provides some insight into the extremely limited extent to which affected individuals anticipate their responses and that of other affected individuals to cope with such economic impacts. Almost none of the focus group members had made future plans for their current housing situation, money owed to state, money for food or money for education. The majority also indicated that their relatives (mostly grandparents) would take care of their children if they died. Only 26% of the interviewees with a HIV positive status have a funeral policy. Only 14.7% have insurance policies taken out with their children as beneficiaries, while only 8% of the HIV positive members of the households have a will. This suggested that HIV positive individuals are undertaking almost no formal future planning strategies. Close to 70% of the households that were interviewed indicated that they had no plans for the money they owed, while, 12.3% indicated that their relatives would take care of it, and another 8.2% relied on their employers. Only 0.5% indicated that this burden would be paid off by their savings. The emerging picture is that not only are HIV- and AIDS-affected households submitted to substantial economic stress in the short term, but the absence of forward planning for longer-term economic survival also means that livelihood generation opportunities in the longer-term are uncertain.

HIV and AIDS affect the context in which municipalities govern and the meaning of developmental local governance

The implications emerging from the above are manifold. First, they tend to confirm the conclusions reached in the section engaging with the macro-level demographic and economic impacts. Household pauperisation is likely to increase indigence levels and related municipal financial burden, by increasing the number of households which are no longer financially viable from a municipal perspective.

In turn, this may require increases in rates and service payments contributions from other households. In this context, the politically arduous question of mutual subsidisation within a municipal constituency is likely to resurface.

Furthermore, demands on the local economic development competency of municipalities will intensify. Historically, local economic development interventions have not necessarily targeted poverty alleviation. Instead, provincial departments of welfare have increasingly been tasked with taking measures such as the distribution of food parcels. In a context of household pauperisation, it is likely that municipalities may increasingly be called upon to revise the nature of their economic development roles to take on a poverty alleviation role which they have not been institutionally geared to do.

Social impacts

The wide ranging household demographic and economic impacts also have far-reaching social impacts. To start with, they affect the household profile. The following section explores some of the household and community composition impacts and draws implications in terms of livelihoods and social fabric.

HIV and AIDS change household profiles

The household structure which most housing and land delivery policies are premised on is becoming increasingly at odds with the reality of South African urban and peri-urban households. It is worth noting that whilst little empirical research has been done to establish a typology of household, it is also unlikely that, historically, the majority of households have neatly followed the nuclear model of two parents with children on which policy is premised. Instead, a wide array of household types with multiple generations and transient members has been identified, in parts due to the distorting impacts of Apartheid urbanisation policies. HIV and AIDS are a new factor of household profile transformation.

In the Booysen study, it was found that affected households are on average slightly larger than non-affected households and that the dependency ratio in affected households is higher than that in non-affected households. This implies that households affected by HIV and AIDS have a smaller supply of labour than non-affected households, with a larger proportion of children and elderly persons. The Health Systems Trust research noted the sudden growth of HIV and AIDS affected households, being augmented by orphaned children and unemployed family members, once the impact of morbidity in the household and its extended family sets in.

The Booysen study highlighted the fact that almost a third of households – both affected and not-affected – in the sample sheltered at least one orphaned child. It found that mortality in particular induces household migration among affected households, especially among younger persons. Typically, the change in household size coupled with a change in dependency ratios suggests that households are becoming poorer, because they have to stretch their already meagre assets to cover more members. Reliance on extended family structures has resulted in severe overcrowding, which can lead to hygiene and sanitation problems (BESG, 2001). This emphasises the fact that, even if households do not contain an HIV infected individual, they are vulnerable to the effects of HIV and AIDS morbidity and mortality, thus stressing the pervasive nature of the social impacts of HIV and AIDS.

HIV and AIDS introduce chronically vulnerable household profiles

In the Khayamandi study it was found that children headed almost 5% of the households in the survey sample. Although this is a substantial proportion of the sample, it is worth noting that the research specifically targeted HIV-affected households. Nevertheless, it is also worthwhile considering the implications which the existence of child-headed households bears in terms of livelihoods and more directly in terms of engaging with local government. It is estimated that there will be almost 2,1 million orphans by the year 2010 (CSA, 2002). Different household formation routes may be available to orphans in the South African context. The Cross study is particularly informative in respect of the new types of household profiles emerging from the social impacts of HIV and AIDS. It offers insights into a variety of household profiles that have pooled together as a means to weather the impacts of the pandemic and of poverty. Importantly, the study highlights the lack of clarity of the term "child-headed" in terms of age as well as dependency profile. It explores the emergence of households of orphaned young adults aged between 18 and 25 with or without children who temporarily come together, and notes that some young adults return to live with their parents and/or grandparents once a partner has died or once they themselves become ill. This type of practice is important to consider in relation to the assets available to the receiving households. Typically, these include land or housing or in the case of grandparents a monthly pension which provides some, albeit limited, regular income. The research makes specific mention of the emergence of a class of floating young adults who are unable to settle because shelter options are increasingly being limited to informal rental tenure. The Khayamandi research found that almost none of focus group interviewees had made future plans for the care of their dependents. The majority indicated that their relatives (mostly grandparents) would take care of their children in the event of death.

Only 8% of the HIV positive members of the households had a will. As Tomlinson (2001) notes, the shelter needs of particularly vulnerable households may not be met by maintaining them on land and in housing units that they can ill afford and that do not meet their socio-economic care requirements. There is some media-related evidence that in an effort to become financially viable, vulnerable households are informally renting land in their backyard or rooms in their house to earn a survival income. While this may indeed be a critical coping strategy, it has also given rise to situations where the tenants, realising the vulnerability of the household, take over the household and the property.

Vulnerable households have different requirements from, and abilities to engage with local governance systems and services, aside from a quasi-obvious inability to sustain the costs associated with the consumption of services and the property taxation system. In particular, they may be particularly unable to engage with bureaucratic matters related to land use management and administration. On one hand, this may increase informal and unregulated land uses and developments; on the other, it may also precipitate vulnerable households into a situation of illegality. Further, their socio-economic vulnerability is likely to be combined with some experience of stigmatisation, thus making them unable to engage with the existing civic and democratic structures and processes. Indeed, it is likely that such households will least be able to organise themselves as a visible intermediary which local governance processes can engage with, or that is able to articulate its particular development requirements through existing institutional channels.

Community and settlement level impacts

Some research has been undertaken on household level impacts. Community-level impacts have yet to be investigated. However, considering the results of some empirical research together with anecdotal evidence gathered through interaction with role-players suggests issues for consideration. Two perspectives have been noted. The first perspective is that where social networks are strong and self-regenerating, they offer a level of protection from socio-economic impacts. The second perspective posits that by drawing on social networks to weather the socio-economic impacts of HIV- and AIDS-affected households weaken and strain these networks and those households that are not directly affected. These perspectives are neither entirely complementary nor contradictory, and would require dedicated empirical enquiry, but need to be borne in mind.

Anecdotal evidence suggests that strong social networks offer protection to vulnerable households in the face of HIV and AIDS. For instance, in the Development Works study, it was reported that the extensive community mobilisation involved in the people's housing process provides a platform around which to consider and respond successfully to the socio-economic impacts of HIV and AIDS at the household and community level. The durable mobilisation and development ethos practiced by the Homeless People's Federation has seen communities intervening to protect vulnerable households from the usurpation of land rights by relatives after the death of the household head. These responses suggest that social networks can support HIV- and AIDS-affected households.

Yet, it is also possible that in communities that are equally cohesive, the community-level impacts may exceed the sum of the impacts on households , thereby turning social assets into social liabilities. In the Booysen study, it was found that, where borrowing was used as a financial coping strategy, in more than 60% of cases the money was borrowed from relatives and friends. In the Khayamandi study, expectations that family and friends would provide guardianship and debt repayment support is emphasised above. Rural settlement level research undertaken in the Mont-Frere area (Economic Policy Research Institute, 2002) indicated that the social custom of providing material and emotional support to bereaved persons is fast depleting assets held within the community, so that even households that are not directly affected by the death of a member come under strain in order to support those that are. Although this practice is entrenched within a rural setting, it is probable that it persists – even in a diluted or transformed manner – within urban settings; after all, the practice of burial collections in the workplace is very much alive. Similarly, sheltering orphans is increasing the vulnerability of weak communities. These and other concerns suggest that there may be vulnerability thresholds for socio-economic networks beyond which HIV and AIDS impacts precipitate communities. In such an ultra-vulnerable context, the ability of communities to engage with local governance systems can be severely undermined.

2.4. HIV and AIDS impact on the municipality as an employer and service provider

Having considered how HIV and AIDS can impact the municipal sphere through the context which it means to serve, the paper now turns to the municipal impact from an institutional perspective.

2.4.1. HIV and AIDS affect officials and politicians and thus the municipality's ability to govern

Municipal policy and legislation do not particularly differentiate between the roles of political stakeholders from other municipal role-players such as officials and uses catch-all terms such as "the local authority", "the municipality", "local government". The lack of prescription is appropriate in as much as it assumes that the elected body of politicians has the ultimate decision-making role in matters related to municipal planning and implementation, and that officials perform a supportive function to all these processes. This latter point is made particularly explicit in the Municipal Structures Act 117 of 1998. Nevertheless, this means that, potentially, HIV and AIDS can impact on both the political and the administrative arms of the municipal sphere in a way that affect politicians' ability to govern and officials' abilities to implement the formers' decisions. Although a process is under way to pilot prevalence surveys within particular municipalities, there is no clear estimate of susceptibility or vulnerability to HIV and AIDS impacts on the municipal sphere from a governance perspective. It is, however, likely that current institutional weaknesses in the municipal sphere could be aggravated by the impacts of HIV and AIDS directly as well as indirectly. Typically, this could affect matters ranging from day-to-day operational management by officials as well as more formal decision-making processes requiring council resolutions. Even disruptions in seemingly mundane occupations could, over time, result in more systemic and far-ranging institutional destabilisation.

2.4.2. Municipal institutions are intrinsically vulnerable to HIV and AIDS impacts

No other sphere of government has undergone as much institutional transformation, on an ongoing basis, as the municipal sphere. The re-demarcation and restructuring of municipal government have affected the municipalities' ability to perform this function over spatial jurisdictions previously catered for by other organs of state. This municipal demarcation process was undertaken as an interim arrangement and resulted in the creation of close to 850 municipalities across the country. This was the first wave of demarcation. In 2000, a second wave of demarcation was undertaken to bring down the number of municipalities to 284 municipalities, including local and district as well as metropolitan municipalities. This process has and continues to have significant bearing on the manner in which local government operates. For one, it has created new institutions and administrations through amalgamation. It has also seen the creation of areas of jurisdiction of a much larger scale, and developmental diversity by integrating rural and urban areas under single municipal entities.

More importantly, it has also transformed the fiscal setting of local governance by bringing together settlements of widely differing socio-economic profiles under one fiscal constituency (for redistribution purposes). It is, thus, important to stress the intrinsic vulnerability of the municipal sphere as an institutional component of the state which has undergone substantial transformation, to the disrupting implications of HIV and AIDS. Of note in this respect are the findings of research undertaken by Development Works on the economic impact of HIV and AIDS on the construction sector, and in turn on the implementation of the housing policy. Although housing sector-focused, the research considered HIV and AIDS impacts on the municipal sphere as one of the elements in the implementation of the policy. It found that specific demographic impacts have the ability to disrupt development project implementation, especially where critical roles are affected and in those provinces in which sourcing key roles is currently difficult.

In addition, officials are employed by the municipality thus making local government vulnerable to similar impacts which any other employer faces in respect of AIDS-related illnesses and deaths. Sunter and Whiteside (2000) identify the costs associated with HIV and AIDS at the company level to include:

- Increased absenteeism because of the ill-health of employees, time taken by workers who are also care-givers, and compassionate leave;
- Sagging workforce morale;
- Decrease in productivity linked to morbidity and a reduction in the ability of workers to take on physically demanding activities;
- Decrease in workplace safety because of morbidity-related fatigue;
- Increased replacement costs associated with training of new staff;
- Fall in the average age and experience of labour as new and younger recruits are mobilised;
- Employers may compensate for the expected loss of their workforce during apprenticeship and counteract absenteeism by increasing the size of their workforce;
- The attrition of skilled labour pools will cause wages to rise;
- The communities in the neighbourhood of a business are needing more support to weather the crisis;
- Rising hospital, health care and health benefits costs;
- Personal loans granted to employees have to be written off in the case of AIDS deaths.

It is unclear whether the economic impact of HIV and AIDS on municipalities has been modeled on the basis of the above considerations to reflect the range of municipal profiles and settings found in practice. What is clear is that municipalities are likely to see their financial viability systemically threatened . The preparedness of municipal budget processes to cater for these impacts is, however, more obscure.

3. RESEARCH FINDINGS

Having established the rationale for considering HIV and AIDS matters through IDPs and unpacked the potential areas of impact of the pandemic on local development and its implications for local governance as well as for the municipality as an institution, the paper now presents the findings of the in-depth investigation of the IDPs. It does so by exploring their various components as provided for by legislation, and refined by specific guidelines, and then by reflecting on the nature and coverage of HIV and AIDS impacts and responses in:

- The situation analysis and priority issues;
- Objectives and strategies;
- Projects;
- Integrated sector plans and programmes;
- In terms of evidence of horizontal and vertical alignment.

3.1. Nature and extent of coverage of HIV and AIDS impacts in situation analysis

In line with adopting the IDP methodology as the point of departure, the first part of the research considered which municipalities covered and investigated HIV and AIDS as part of their current reality analysis. There may be a range of events where HIV and AIDS are explored in terms of the analysis phase of the IDP. The key processes and activities recommended as part of this analysis phase include, as per the methodology Guide Pack (2001):

- An analysis of service gaps and resource potentials;
- A participatory-based community and stakeholder level analysis;
- Cross-sectoral municipality-level analysis in respect of (a) economic, (b) environmental, (c) institutional, (d) spatial and (e) socio-economic matters;
- The prioritisation of issues;
- An in-depth analysis of issues.

The purpose of this analysis is to identify and explore the various issues affecting development circumstances in the municipal area of jurisdiction. In turn, this is meant to enable the prioritisation of issues which then informs the forward planning intentions of the IDP. These analyses are meant to be informed by a range of sources (existing information, community participation, dedicated studies, etc.) and processed through both desk-top and participatory events. Participatory events include both direct consultation with community members and structured participatory fora such as the IDP Representative Forum, which brings together representatives of stakeholders.

A keystone of the IDP is the concept of prioritisation. As such, an important step in the analysis involves defining which issues shall be taken forward in the subsequent planning phases, and which shall not be dealt with as part of the IDP. This aims to ensure that the scope of the IDP is focused on the burning issues within available resources constraints. The methodology stresses that priorities should be issue-based, as opposed to sectors (such as water or roads) or projects (such as "houses" or "title deeds"). This approach aims to support strategy making that makes efficient and effective use of resources and addresses the cause (as opposed to the symptoms) of a particular problem. The specification of the priority is meant to include a clarification of the facts and figures related to the issue, differentiated by geographical area and social category, its trends, dynamics and context as well as the resources available to address it. This information is meant to be derived from the analysis undertaken before the prioritisation activities as well as in-depth analysis where available information is deemed inadequate. The in-depth analysis is meant to include a consideration of the issue from cross-cutting development perspectives such as gender or environmental sustainability.

This sub-section asks the following questions:

- Have the municipalities considered HIV and AIDS issues in their current reality analysis?
- What specific aspects and impacts of the pandemic were engaged with?
- In terms of which IDP analysis activities and events were HIV and AIDS issues considered?
- Do the municipalities that address HIV and AIDS in their current reality analysis identify it as a priority issue?
- If so, in terms of what category(ies) of impacts do these municipalities specify HIV and AIDS as a priority issue?
- Do the municipalities that address HIV and AIDS in their current reality consider HIV and AIDS implications in terms of non-HIV and AIDS issues?
- Are there gaps between the current reality analysis and the specification of the priority issues in terms of specific impact categories? If so what are they?
- What is the nature of the other priority issues?

3.1.1. Most IDPs consider HIV and/ or AIDS in the current situation analysis

Encouragingly, it was found that only 1 out of the 11 IDPs had not made reference to HIV and/or AIDS in its analysis of the current situation. This exception was found in the un-reviewed IDP of one of the local municipalities in the West Rand District Municipality. While the depth of analysis of HIV and AIDS matters varied extensively, the primary lens of analysis for such matters was firmly anchored within the ambit of morbidity and/or mortality matters. In other words, the IDPs analyses discuss primarily the pandemic as a force which impacts the demand for health care services and cemetery space. This tendency to pigeon-hole the matter is mostly reflected in IDPs that were not reviewed. The reviewed IDPs, on the other hand, had expanded their investigation to consider HIV and AIDS related socio-economic impacts on affected individuals and households. There, while concern for the pauperisation and indigence of affected households as well as the lack of parental care of orphans was expressed, it did not appear to extend to the broader communities of which affected households are part. Further, only a few IDPs note that HIV and AIDS may impact political participation and civic mobilisation processes. Even fewer consider how it may impact local economic development. Finally, while some note that HIV and AIDS may impact the municipality from a workplace perspective, none considers the possibility of HIV and AIDS affecting the functioning of the political body.

3.1.2. HIV and AIDS are seen to impact on the demand for cemetery and health care services

It is in respect of health and cemetery services that HIV and AIDS emerged in the analysis of service gaps and resource potentials. Cemeteries are clearly specified as a municipal function, and have thus often been considered as part of the analysis of services gaps and resource potentials. Competency over health services is becoming increasingly a provincial function, although some municipalities have historically performed some health services (in particular municipalities which have been established in areas of jurisdiction of the local authorities of the former Republic of South Africa). In most municipalities, therefore, some form of health service is still being performed by municipally employed personnel, using equipment and resources procured by the municipality. Even though the current legislative process due to finalise the allocation of health competencies reaffirms the provincial competency, most municipalities would still have been inclined to include some sort of reference to health services gaps and potentials in their IDP.

The manner in which HIV and AIDS issues were explored, in relation to health services, made reference specifically to increased incidence of HIV- and AIDS-related diseases, such as tuberculosis, thrush, pneumonia, cancers, increased infant morbidity and mortality, and, in certain cases where ante-natal and neo-natal HIV testing is monitored and reported in the IDP, stark increases in prevalence rates among women frequenting ante-natal clinics. In all cases, bar one, escalating numbers of AIDS-related diseases were linked to increasing HIV prevalence rates. In such cases, the problem was characterised as placing severe strain on personnel and other resources. In the case of cemeteries, increased morbidity, specifically related to HIV and AIDS, coupled with the historical under-provision of cemetery space were identified as the main contributing factors behind the increasing inadequacy of cemetery infrastructure. Three out of the eleven IDPs note the rising incidence of informal burial and associated environmental health risks. Yet, none of the information pertaining to basic municipal services such as water, sanitation, electricity or refuse removal makes any reference to how the pandemic may affect the overall backlogs in service provision, and they do not explicitly consider what the service requirements of infected individuals and affected households may be either.

3.1.3. HIV and AIDS make their mark on the IDP community consultation inputs

HIV and AIDS now appear on the list of community needs along matters such as "access to water", "need jobs", "RDP houses", "title deeds". The extent of specification of the need expressed varies between the municipalities. The IDPs scrutinised do not equally elaborate on the consultation process they have followed in order to identify community priorities. Yet, there is evidence that, where facilitated and structured consultation based on socio-economic groupings and representative stakeholder fora occured, the extent of specification of the need is greater than in places where mass-meetings were held to generate lists of needs. For example, in Ethekwini significant emphasis was placed on identifying the specific challenges facing different socio-economic groups. There, the impacts of HIV and AIDS were identified particularly by women and the youth. Similarly, in Ehlanzeni a dedicated task-team was set up to explore the ramifications and development implications of HIV and AIDS. This task team included non-governmental organisations, provincial sector departments as well as officials and councillors. This practice falls within the ambit of the suggestions contained in the Guidelines, where the involvement of advocates for issues and organisations that are particularly active in dealing with specific matters is seen to support and enrich participatory inputs. In some parts of Mbombela (in the Ehlanzeni district) surveys were conducted with a range of role-players. There, the particular socio-economic impacts of HIV and AIDS were articulated in detail.

Where consultation processes only generated long lists of undefined projects, HIV and AIDS impacts were simply documented as "HIV/AIDS", "HIV/AIDS centres", "AIDS Orphanage". It is also possible, although speculative, that HIV and AIDS impacts hide behind community articulated needs such as "24-hour clinic", "hospitals", "food" and "cemetery". The lack of facilitated discussion with communities as a means to identify issues generally implies that the root cause of problems does not surface. Instead, the presumed means of addressing the symptoms of particular conditions are recorded. If communities are not probed deeper and are not given the opportunity to explore and confront the real issues facing them, then, what finds its way into the IDP are broad and unspecified sectors or projects. Where it exists, this practice is not limited to a particular sector, such as health, but characterisesall participatory contributions to IDP. For example, in one IDP, the process of identifying and analysing community and stakeholder issues generated close to twenty-five pages of bulleted lists of project keyword. In such cases, HIV and AIDS keywords never include the likes of access to medicine, voluntary testing, HIV awareness campaign or even prevention of mother to child transmission. Yet, as will be discussed further in the section of this article pertaining to IDP projects, the latter are the primary types of IDP project responses to HIV and AIDS, thus highlighting further the lack of influence which too broad consultation practices have on the strategic contents of the IDP.

3.1.4. HIV and AIDS impacts are addressed in some municipality-wide analyses

HIV and AIDS were identified as a municipal-scale issue in five out of eleven IDPs, primarily in relation to the socio-economic and institutional components. The implications of HIV and AIDS on the ability of the municipality to operate as an institution were identified as a challenge in the institutional analysis sections of four IDPs. In such cases, impact potential, rather than evidence of impact, was specified. In other words, there does not appear to be evidence of HIV- and AIDS-related mortality or morbidity in municipal workforces. Potential impact was expressed only in relation to the labour force of the municipality, never in relation to the elected body of politicians: while HIV and AIDS were considered to present a risk to the municipality as an employer, the potential disruptions of the decision-making role of the municipality, through councillors, was not documented in any IDP. It is worth highlighting that none of the eleven IDPs actually considers the political arm of the municipality as part of the institutional analysis.

Arguably, this constitutes an important shortcoming, as it suggests that the analysis of the municipality as a sphere of government fails to consider the role performed by politicians, irrespective of HIV and AIDS. Finally, the institutional analysis makes reference to HIV and AIDS where a direct impact on the municipality's resources is experienced; for instance in respect of cemetery space and, where applicable, in relation to the increasing burden of care straining the provision of health services. This has already been discussed above.

The implications of HIV and AIDS on socio-economic issues are documented in five out of eleven IDPs. Generally, the social analyses are extremely data-focused and rarely analytical. For instance, statistics such as the number of clinics, average number of learners per class, number of orphans and the number of pensioners in the municipality were documented without any interpretation of how such statistics could affect development conditions within the municipal area. In turn, the related governance requirements from the municipality or other organs of state were overlooked. Similarly, HIV and AIDS dimensions often reflect estimates of prevalence and incidence of AIDS cases without further analysis. Some exceptions to this general rule exist. The reviewed IDPs tend to explore the social dimensions of HIV and AIDS in relation to local governance. In some cases, the developmental impact of HIV and AIDS was interpreted in terms of increasing socio-economic vulnerability, specifically in respect of orphans and their care givers, as well as decreasing food security. Across the IDPs HIV and AIDS were aggregated with matters that are generally not easily reconciled with municipal line functions such as “poverty”, “gender” and “crime”, and even the somewhat odd category of “social pathologies”.

In the other municipal-wide analysis items, HIV and AIDS appear to have been considered only marginally. Only one IDP identifies unemployment as a factor that may drive HIV and AIDS within the area of jurisdiction of the municipality, claiming that the unemployed will turn to “prostitution and crime” for income generation. Another IDP notes that informal settlements are particularly prone to the spread of HIV, in the section of the IDP documenting the environmental analysis. Aside from what these assertions reveal about how the pandemic and its drivers are perceived, the obvious absence of concern for HIV and AIDS impacts in the other types of municipal-wide analyses is particularly telling. Indeed, none of the sections of the institutional analyses pertaining to the financial situation of the municipality consider how the pandemic may affect revenue generation. Similarly, not one economic analysis reflects on how the pandemic may affect economic trends within the municipal area of jurisdiction.

Only one spatial analysis makes reference to the need to, in future, include the spatial mapping of health, home-based care and orphan care facilities as part of IDP review activities. In addition, only one IDP identifies HIV and AIDS as a health risk, albeit on a long list of potential disasters, in its disaster management analysis.

On the surface it would appear that the ability of municipalities to engage with HIV and AIDS issues may be inadequate. Careful scrutiny of the municipal-wide analyses reflects the general inability of municipalities to interpret the implications of sector-based technical information for non-sectoral development issues and, conversely interpret the implications of non-sectoral development information for technical sector planning.

3.1.5. Seven out of eleven IDPs identify HIV and AIDS as a priority issue

Seven out of the eleven IDPs identify HIV and AIDS as a priority issue. This issue is ranked among the lower 50% out of the first 10 priority issues. Most of the reviewed IDPs had included "HIV/AIDS" (as opposed to qualitatively defined aspects of the pandemic) as a priority issue, whereas the original IDPs tended not to have. In considering these findings, it became important to cast the analytical net wider by considering HIV and AIDS within the context of the other priority issues. Importantly, few IDPs contained lists of more than twenty "priority" issues. Even if HIV and AIDS matters are identified within these lists, the sheer number of issues, which the municipality addresses as part of its plan, means that each issue on the list becomes de-emphasised. In turn, this fails to provide the strategic focus required as the basis for planning. Secondly, several IDPs included predetermined projects or sectors as issues. Among those, "water", "roads and stormwater", "housing development", and "electrification" topped the list. A minority of IDPs had emphasised development issues as their priorities, such as "poverty alleviation", "food security" or "safe and secure environment". This suggests that the practice of engaging with issues as opposed to sectors remains difficult to acquire for municipalities.

3.1.6.HIV and AIDS matters are sectionalised

The multi-facetted characteristics of the pandemic imply that if it is to be addressed successfully, it cannot be reduced to one sector or project. Yet it appears that municipal capacity to engage with matters that are not uni-dimensional is limited. There is little evidence that matters other than those addressed within the confines of a technical line-function (e.g. engineering services, electricity or revenue), such as HIV and AIDS, poverty, gender, sustainability are adequately considered from an institutional perspective, or that data-based and technical analysis consider such matters.

A partial exception is the Ehlanzeni District, where a dedicated in-depth analysis process was undertaken between the District and the Local Municipalities, which contributed to expanding the definition of HIV and AIDS impacts, to include not only socio-economic but also socio-political impacts, and in particular the challenge which the pandemic will generate in terms of civic mobilisation and political participation. In this district, the documented IDP analysis findings even identified the possible effect of the pandemic on the overall level of economic development. Importantly, the process of setting up this task team sought to reconcile both participatory input requirements and a concern for technical proficiency. As a result, there was evidence that the implications and requirements of HIV and AIDS issues were considered in some of the sector-based contents of the IDP, although not all. Similarly, in one of the local municipalities of the West Rand District, a detailed socio-economic analysis was undertaken which engages substantially with the implications of HIV and AIDS from a social development perspective and explores how the socio-economic circumstances in the municipal area of jurisdiction interface with the pandemic.

3.1.7. The implications of the localised characteristics of the pandemic for local governance are not explored

Overall, it would appear that few of the municipalities undertook in-depth analysis activities, not only in respect of HIV and AIDS matters. Incidentally, it would appear that where such analyses where undertaken, the level of understanding of HIV and AIDS implications for local development circumstances is significantly more complex and specific. In the absence of an in-depth analysis on HIV and AIDS, the underlying or causal factors identified are broad and not localised. For instance, mention is made of factors such as the presence of "aliens" within the municipal area of jurisdiction, the incidence of "social pathologies" such as "women abuse", "alcoholism", "vagrancy" or even "moral degeneration" as the key drivers of the pandemic. In almost all IDPs, there is no reflection about how the particular local context affects local prevalence patterns and in turn their implications for existing local development trends.

Six out of the eleven IDPs specified the issue in terms of the current spread of the pandemic. In such cases either provincial or, where available, health district ante-natal prevalence rates were quoted. It does not appear that actuarial projections were undertaken in any of the eleven municipalities. Some conclusions were inferred from these rates.

For instance, the Ethekwini IDP notes that the population growth rate in the metropolitan area of jurisdiction has been reduced to nought, but does not reflect on which demographic groups, in terms of age, gender or race may be most affected or what the implications of these demographic trends may be for the municipality's governance roles. More than half out of the eleven IDPs mention increased morbidity and mortality. It is in respect of both these facets of the pandemic that an attempt was made to reflect on their implications for the governance role of the municipality. In other words, the specification of the priority issue identified that HIV and AIDS would affect the demand for health services on the one hand and/or cemetery space on the other. Strikingly, even in such cases, it does not appear that the range of implications of HIV- and AIDS-related morbidity and mortality for local development circumstances were systematically considered. Less than half the IDPs considered in this research specified the impacts of HIV and AIDS from a socio-economic development and/or workplace perspective. HIV and AIDS implications are at times considered in the definition of other priority issues, although not systematically.

Finally, it is important to note that in the specification of the HIV and AIDS priority issues, several of the dimensions explored either in the current reality analysis or in the in depth analyses are discarded. They include socio-economic aspects, household-level impacts and workforce impacts. This narrowing down of the definition of the priority issue is to the benefit of items such as health services, a focus on HIV prevalence rates and infected individuals.

3.2. HIV and AIDS in IDP objectives and strategies

Setting objectives and formulating strategies to address priority issues are the methodological steps which follow the identification and specification of priority issues in the IDP methodology. The strength of an objective is conditional on its link to the underlying causes of the issue it aims to address. In other words, in relation to HIV and AIDS, this means that the particular facets of the pandemic that have been identified and specified as HIV and AIDS priority issues (or even other issues) need to be engaged with in terms of the related objectives. Furthermore, objectives should aim to be realistic, feasible and specific as to the expected benefit and the proposed time-frames. This includes specifying measurable targets. Once an objective has been articulated in relation to a particular priority issue, strategies can then be formulated that are both informed by the local context and the strategic guidelines of the other spheres. The strength of a strategy depends on it clarifying the major fields of intervention for the objectives to be met.

This sub-section asks the following questions:

- What are the objectives and strategies municipalities have formulated in respect to HIV and AIDS priority issues?
- In which category of responses do those fall and what is their target?
- Do the objectives and strategies appear feasible?
- Do they appear to be linked to the specification of the priority issues?
- Are these findings applicable to objectives and strategies that do not specifically relate to HIV and AIDS issues?
- Are the objectives that do not specifically relate to HIV and AIDS issues compatible with a context of HIV and AIDS impacts?

3.2.1. Linkages between the definition of HIV and AIDS as a priority issue and objectives are incomplete

The assessment of objectives reveals, firstly, that even in instances where the specifications of HIV and AIDS issues encompasses the multi-facetted characteristics of the pandemic and its impact on local development, the range of characteristics which the objectives target is substantially narrower than that described in the specification of the priority issue. Indeed, most objectives focus on reducing prevalence levels. Some objectives engage with the impact of the pandemic on affected individuals in particular. The themes of "care for HIV/AIDS patients" and "availability of care for AIDS orphans" were recurring across most IDPs. Workplace-related objectives were found in a minority of IDPs and focus on the protection of workers' rights and the provision of some form of medical treatment for infected workers. Even where HIV and AIDS were identified as the underlying factor for a particular issue (for instance in relation to increasing backlogs in the provision of health care- or cemetery-related services) the objectives make no reference to it.

3.2.2. Some HIV - and AIDS-related objectives are technically weak

The extent to which the formulation of the objectives adequately meets the criteria of realism, feasibility and specificity vary. In most cases the objectives did not include either time-frames or targets for achieving the objective. The lack of specificity was most obvious in relation to the target group which the objectives were aimed at. For example, awareness raising objectives did not specify among which group awareness should be raised. On the other hand, where an attempt to be specific was noted in terms of quantitative targets and time-frames, this was at times at the expense of feasibility. For instance, some IDPs included objectives that aimed to "decrease infection levels in the municipality by 50% in the next five years" or event to "eradicate HIV/AIDS from within the municipality by 2007". Although the lack of specificity of objectives is not strictly limited to HIV and AIDS, in several IDPs, the apparent lack of feasibility of some HIV and AIDS objectives is.

3.2.3.HIV- and AIDS-related strategies narrow down considerably the impacts being addressed in the IDP

The assessment of the strategies formulated in terms of the objectives confirms the picture sketched in respect of the objectives as a progressive narrowing of the response to HIV and AIDS issues in favour of prevention strategies. Ten out of eleven IDPs include at least one strategy on awareness raising as a means to prevent further infections within the municipal area. This pro-active prevention strategy is however limited by the lack of specificity regarding target groups or spatial dimensions. Within this broad category of awareness raising strategy, partnerships are seen as a key area of intervention. "Partners" are generally not specified. Where they are, they include different organs of state, CBOs, NGOs and the local AIDS councils. Among the list of potential partners, no mention is made of either private sector role-players or customary authorities. Presumably, one might have assumed that in the case of the West Rand local municipalities, the mining sector, which is already active in the field of HIV and AIDS, might have been identified as a partner of choice. Similarly, in the Ehlanzeni district local municipalities, customary authorities are important role-players whom one might have expected to have been identified. The second most frequent type of response are health care focused, ranging from institution-based health care (i.e. improve access to clinics and hospitals) and home-based care, to prevention of mother-to-child transmission and voluntary testing and counselling. These strategy fall squarely within the ambit of the national strategic response to HIV and AIDS. A minority of IDPs are planning to enhance access to medicine, without specification. While this may be blamed on a tendency for municipalities to sheepishly follow national programme and strategy directions for which funding and support is made available (as can be seen in most sectors where subsidies are allocated and administered through national programmes), it can also be ascribed to the inability of most IDPs to unpack the range of impacts of HIV and AIDS in terms of development and local governance.

Several IDPs adopt a "planning to plan" strategic response, and specify that they will conduct research to assess prevalence, develop workplace policies and/or a "comprehensive HIV/AIDS strategy". The "planning to plan" type of response is not specifically limited to HIV and AIDS matters and is also evoked in relation to several of the statutory planning requirements of sector departments. These types of responses were mostly found in the un-reviewed IDPs, although not exclusively. Even the Ethekwini's "mainstreaming responses to crime, HIV/AIDS and poverty alleviation" strategy does not specify each line-function's responsibility to respond and how the partnerships will be set up.

Overall, only four out of eleven IDPs have developed strategies that aim to respond to the socio-economic impacts of HIV and AIDS. This means that two IDPs that had identified socio-economic impacts of the pandemic have not responded to those in their strategies. There strategies aim in the main to establish social safety nets for basic food security, access to social grants, poverty relief, orphan care and income generation opportunities. Finally, four IDPs include some form of institutional capacity building responses. These are translated into projects about appointing an official whose title is loosely phrased as "HIV/AIDS co-ordinator".

3.2.4. The implications of HIV and AIDS impacts are not considered in relation to other strategies

Turning to the strategies in the IDPs that are not specifically related to HIV and AIDS, the overwhelming finding is that there is little evidence that the impacts of the pandemic have been considered, save for health-specific strategies. In only one IDP, Elhanzeni's, is there evidence that at least one set of sector-focused strategies, pertaining to education, not only consider the role which the sector can play in supporting the HIV and AIDS specific strategies of the IDP, but also engages with the impact which the pandemic may have on the sector, in terms of demand for services and capacity to deliver education services. Paradoxically, several IDPs while identifying that HIV and AIDS would have far reaching impacts on the levels of poverty in the municipal area of jurisdiction, have developed financial strategies that are about increasing service charges or improving the revenue collection system.

3.3. HIV and AIDS in IDP projects

The IDP methodology provides for the formulation of projects to implement the strategies. Although the methodology acknowledges that some projects can include routine maintenance and existing projects, it also specifies that IDP projects should fundamentally relate to the achievement of the objectives and strategies, and address the priority related issues. To ensure that the IDP comprises more than what has come to be referred to as "paper projects", the guide specifies that the projects documented in the IDP should contain sufficient information to support implementation. Key information fields pertaining to the design of the project are meant to include aspects such as the target group benefiting from it, its spatial location, quantitative outputs, objectives and indicators, capital and operational costs year on year, sources of finance, institutional responsibilities and key activities. From an HIV and AIDS perspective, the projects were first considered in terms of whether they were linked to the strategies and objectives formulated in response to HIV- and AIDS-related priority issues as well as whether they are sufficiently specified to support implementation.

This sub-section asks the following questions:

- What projects have been formulated in respect of HIV and AIDS objectives and strategies?
- Is there consistency between the nature of the impact categories identified in the priority issues and the categories of responses developed? If not what are the key gaps?
- Are the other kinds of projects developed in the IDP compatible with a context of HIV and AIDS?
- Has a budget been allocated for the HIV- and AIDS-related projects in the project description?
- How does the budget allocation for HIV and AIDS projects compare with that of other kinds of projects?

3.3.1. The original range of impacts and dimensions of HIV and AIDS is reduced to epidemiological and health projects

An assessment of the type of projects developed and documented in the IDPs confirms the gradual attrition of the scope of intervention in terms of identified HIV and AIDS. The original range of impacts and dimensions is progressively reduced to epidemiological and health matters projects.

Most HIV- and AIDS-related projects contained in the IDPs deal primarily with reducing prevalence levels. The most common project appears to be about setting up and rolling out "awareness campaigns" with a view to induce behavioural changes. Close followers of this IDP favourite are the setting up of "information centres", "training of councillors", "voluntary testing sites" and even "plays". Importantly, the target group for these interventions are never specified, suggesting a lack of discernment about the differentiated vulnerability of socio-economic and demographic groups. The second type of projects which routinely find their way into the IDPs are health sector responses, in the form of the development of a "24-hour clinic", "home-based care centres", "hospices", "AIDS-havens", as well as yet undefined "TB and AIDS programme", "PMTCT programme", "VCT", "palliative care" and "home-based care" projects. Importantly, while awareness raising projects found their way in all IDPs, health sector projects were found in eight out of the eleven projects.

Socio-economic safety net projects to alleviate the socio-economic impacts of the pandemic were found in four IDPs. Such projects are related to the protection of basic nutrition, poverty alleviation through basic income generation opportunities, facilitating access to social grants, fostering parent training and supporting initiatives to care for the shelter needs of vulnerable groups.

Fewer IDPs include projects related to the establishment of socio-economic safety nets for vulnerable groups (i.e. not specifically HIV and AIDS affected households or individual) other than those which identify the pauperisation of municipal constituencies as an impact of the pandemic, as well as those that highlight declining socio-economic conditions within their area of jurisdiction. Four out of the eleven IDPs anticipate appointing an "HIV/AIDS co-ordinator to develop and implement an HIV and AIDS programme". The definition of the scope of responsibilities or role of this appointment-based project is blatantly vague. Although several IDPs included "planning to plan" strategies, few have translated these strategies into projects such as prevalence and impact assessment studies, or workplace orientated projects in the form of the formulation of a workplace policy. Finally, only three IDPs propose to undertake social stigma alleviation projects, mostly in the form of "world AIDS day celebrations".

3.2.2. Most IDPs include HIV- and AIDS-related projects that are not sufficiently specified to be implemented

While some IDPs demonstrate that an attempt was made to specify some of the information fields required for project implementation, generally the information provided remains limited. This suggests that by and large the implementability of HIV and AIDS projects as documented in the IDP is doubtful. Yet, it is necessary to clarify that where HIV and AIDS related projects are insufficiently specified for implementation, all other projects are equally so.

3.3.3. The weakness found in respect of HIV-and AIDS-related projects are reflected in other projects

On the surface, the gradual narrowing of the range of HIV- and AIDS-related issues to health and epidemiological matters can be attributed to a lack of awareness of the available interventions which could be made. However, contextualising the other kinds of projects contained in the IDPs demonstrates that this interpretation is partial. Indeed, even those IDPs which explored and prioritised development issues, such as poverty and lack of socio-economic development (as opposed to sectors such as "water") are dominated with hard infrastructure, sector-orientated projects such as "construction of 100 RDP houses", or in the case of newly established municipalities, institutional projects, such as "purchase of furniture, offices, etc.". The infrastructure projects are confined to pre-determined sector programmes to which substantial capital subsidy resources are attached. These findings echo those made in relation to objectives and strategies. Municipalities plan within the ambit of nationally articulated strategies because substantial financial resources are attached to these programmes and because they lack the capacity to plan strategically, and articulate local solutions to the expression of a national problem.

3.3.4. HIV- and AIDS-related projects are generally not adequately resourced

While identifying projects that aim to respond to particular issues is a precondition for ensuring that the planning process generates realistic outcomes, their implementability is ultimately conditional on the availability of both capital and operational finance to first implement and then sustain such projects. The IDP methodology provides that the IDP should contain project specifications that spell out not only the capital and operational expenditure requirements of projects over five years, but also the source of finance for implementing the projects.

It is understood that certain types of projects (especially infrastructure projects) have greater budgetary requirements than others. Considering the linkages between the identification of issues as priorities and the budgetary implications of the projects responding to each issue allows one to consider whether municipalities are effectively responding to the priorities they identify. This is about assessing the extent to which those municipalities that identify HIV and AIDS as a priority issue actually follow this prioritisation in terms of the budget proportion which they allocate to the issue. Simply put, it is about assessing whether such IDPs put their "money where their mouth is".

The first finding relating to the above set of areas of investigation is that not all projects designs specifically dealing with HIV and AIDS issues include a budget allocation, which makes the implementability of such projects questionable. In such cases, failure to specify budgetary implications, both in terms of capital and operating expenditure, is not limited to HIV and AIDS projects. For example, while the Ethekwini IDP does not contain detailed project designs, several of the IDPs of the West Rand District Municipality's area of jurisdiction, not having been reviewed, do not specify the budgetary implications of projects.

The size of the budgetary allocations, via projects, to HIV and AIDS issues was also compared across the municipalities. In this respect, it is worth emphasising that, generally, minimal amounts were set aside to sustain the range of AIDS projects. Cumulatively, in each municipality, these seldom amounted to more than R 100.000 over a three to five year period. The exception to this general rule was found in the Ehlanzeni District Municipality IDP, where the anticipate spending amounted to R 25.000.000 (from its own as well as other revenue sources) on a range of HIV and AIDS projects ranging from health care, home-based care, multi-purpose centre used by HIV and AIDS NGOs, socio-economic projects around poverty alleviation, awareness raising, training and partnerships, to channelling funding to NGOs and CBOs.

Some of the interventions which municipalities can make in respect of HIV and AIDS issues may not be particularly resource intensive, especially where such interventions are partnership-driven. It is perhaps significant that the municipality which has undertaken a fairly multi-disciplinary study under the aegis of a representative stakeholder and role-player based task-team, is the one where most funding is being set aside to support and sustain the implementation of HIV and AIDS projects. This is true not only in terms of their absolute financial value, but also in relation to other budget items addressed as part of the IDP.

3.3.5. Hard infrastructure projects overshadow projects relating to development "issues"

As stated previously, a budgetary allocation to a specific kind of project cannot be considered in isolation from other projects. The first finding in this respect is that, as can be expected, infrastructure projects monopolise, together with salaries, the bulk of the budgetary allocations of all IDPs. Aside from such projects, there appears to be a correlation between those IDPs which place a significant emphasis on development issues, as opposed to sectors (such as "roads and stormwater"), and the share of the municipal budget allocated to projects that address the "soft" development requirements of the municipal area of jurisdiction. In such IDPs, the poverty alleviation and socio-economic safety net share of the budget appears to be greater than in other IDPs. Typically, these projects may be conducive to alleviating some of the socio-economic impacts of the pandemic. A third finding in respect of this comparison is that in three IDPs the share of the IDP budget allocated to cemeteries on an annual basis is on average ten times that allocated to HIV and AIDS projects, even though HIV and AIDS were identified as underlying factors that contribute to the increasing need for cemetery space. In yet another IDP, the total share of the IDP budget allocated to office equipment and furniture is the single most important budget item. In these cases, it is clear that the actual, budgeted-for, priorities are either only addressing the symptoms as opposed to the underlying causes of such issues or a far cry from the developmental concerns evoked in the priority issues. Either way, the overwhelming impression is that such practices do not align with the intentions or underlying principles of a planning methodology that is both strategic and developmental.

3.3.6. Sources of finance for implementation of projects appear unclear and confused

An analysis of the expected sources of finance for implementing the projects yields interesting findings on the awareness of municipalities for accessing resources. Most health care-related projects clearly set out that either the provincial department of health or the district municipality (in the case of some local municipalities) is the responsible funder. In the latter case it may be argued that the municipalities in question have not processed the implications of the assignment of health care services functions. Alternatively, it suggests that they have not engaged with the district municipalities in order to secure the funding necessary for the implementation of a particular project, and indicates a problem of horizontal alignment between the plans of different types of municipalities. In respect of projects that pertain to developing workplace policies and/or an HIV and AIDS strategy, although the municipality is often specified as the funder, the Department of Provincial and Local Government has also been identified as the funder, even though the Department has not made funds available for this purpose to municipalities. This type of situation is symptomatic of a lack of vertical alignment between the plans of the municipality and that of the other spheres of government. Finally, the municipality has been identified as the funder for most awareness-raising projects and socio-economic projects that aim to alleviate the distressed conditions which HIV-affected and other households are faced with. Of note is that the full scope of projects which municipalities see themselves as being able to support, while being contingent on their overall financial and fiscal situation, tends to fall short of the actual range of projects which municipalities could potentially support, even minimally in the form of facilitation and co-ordination.

3.4. HIV and AIDS in integrated sector programmes and plans

The IDP methodology, according to the statute and methodological guides developed by the Department of Provincial and Local Government, advises to compile integrated sector programmes and plans that are meant to aggregate the contents of the IDP pertaining to specific sectors or line functions. This includes in particular:

- A financial plan that addresses financial strategies for the financial viability of the municipality*;
- A capital investment programme that consolidates all capital investment projects over the next five years*;
- An action programme that defines the implementation steps to be taken for each project over a five-year period;

- An integrated Monitoring and Performance Management System that includes performance targets and indicators*;
- An Integrated Spatial Development Framework*;
- An Integrated poverty reduction and gender equity programme;
- An Integrated Environmental Programme**;
- An Integrated LED Programme;
- An Integrated Institutional Programme*;
- An Integrated HIV/AIDS programme;
- A Disaster Management Plan*;
- Integrated sector programmes or plans as required by sector legislation, such as a Water Services Development Plan or Waste Management Plan**.

In the above, those components of the IDP that are specifically required in terms of the municipal systems act and its regulations are marked with a "*", those required by sector planning legislation are marked with a "**".

This sub-section asks the following questions:
- Do the IDPs contain an HIV/AIDS programme?
- Does it capture the range of impacts and responses contained in the remainder of the IDP?
- Does it include a consolidated budget/action plan/responsibilities for HIV and AIDS?
- Do the statutory sector plans and integrated programmes engage with HIV and AIDS issues?

3.4.1. Half of the IDPs considered in the research include an HIV/AIDS Programme

Whereas the law does not prescribe the compilation of an Integrated HIV/AIDS Programme as part of the formulation of the IDP, the guidelines developed by the Department of Provincial and Local Government do. In spite of this, close to half the IDPs researched include an HIV/AIDS programme, in particular all the local municipalities and the district municipality in the Ehlanzeni district. This would seem to suggest that those municipalities are duly recognising the significance of HIV and AIDS issues in their IDP. However, not all the municipalities that identified the pandemic as a priority issue have included an Integrated HIV/AIDS programme in their IDP.

3.4.2. The IDPs do not comprise all mandatory sector plans and programmes

On the surface, one could attribute the failure of those municipalities that identify HIV and AIDS as a priority issue to include an HIV/AIDS programme in their IDPs to the fact that it is not a legal requirement. Yet, it is also evident that among the IDPs included in the research none have developed all the sector plans and integrated programmes required in terms of national statute. Even the Ethekweni metropolitan municipality, which presumably has access to much greater in-house sector and IDP planning capacity than the other municipalities, has developed an IDP that does not include all the core components of the IDP as required in the Municipal Systems Act, let alone sector planning requirements.

3.4.3. The extent of implementability of the HIV/AIDS programmes is unequal

The extent of specification and therefore implementability of the HIV/AIDS programmes varies substantially. Whereas some HIV/AIDS programmes go to great lengths to refer back to the various elements of the IDP dealing with HIV and AIDS, and further specify key implementation-orientated information, such as clarifying institutional responsibilities for implementing the plan, detailing an action plan and a budget for the various activities and projects, others have only compiled a tabulated summary of HIV and AIDS projects. Generally, reviewed IDPs contain HIV/AIDS programmes that are substantially more detailed and specified than IDPs that have not been reviewed.

3.4.4. HIV and AIDS matters are considered in sector plans only in exceptional cases

Only a few IDPs, particularly those in the Ehlanzeni District, make some sort of reference to HIV and AIDS matters in terms of their social plan, health plan (where developed), disaster management plan and institutional plan. Yet, there is no evidence that these matters are reflected in the financial plan or performance management targets and indicators or in the sector plans required in sector statute, such as the Water Services Development Plan, the Integrated Waste Management Plan or the Spatial Development Framework. Although most, if not all of these operational plans and sector plans play a substantial role in guiding not only municipal but also provincial and national budget allocations, there is no evidence that the impact of the pandemic and its specific governance requirements have been considered. This validates previous findings pertaining to the narrowing down of the range of municipal responses to HIV and AIDS issues.

The outcome of this situation is that there is no evidence that HIV and AIDS issues have effectively been mainstreamed into the IDP. Scrutinising the sector plans and programmes to establish whether this finding applies solely to HIV and AIDS issues reveals that this is not the case. Other cross-cutting dimensions of development, such as gender and environmental sustainability, do not easily find their way into sector plans and programmes. This suggests that mainstreaming development issues, as opposed to sectors, is proving particularly difficult in the IDP process.

3.5. Are HIV and AIDS aligned across strategic plans?

Given the layering of sectors and competencies as well as concomitant allocation of budgetary and human resources across the spheres of government, for the range of issues and dimensions considered as part of the IDP to be addressed, it is imperative that the IDP process serves to bring together the strategic plans of the various spheres and sectors. This process and its outcomes are called alignment. There are three types of alignment that should occur as part of the IDP. The first is vertical alignment. It is concerned with the plans and implementation across the spheres of government. Second is horizontal alignment within the municipal sphere, in other words, between local municipalities and the district municipality as well as between adjacent municipalities. The third is alignment between sectors. It has been considered in the previous section in relation to integrated programmes and plans. Thus, it is the other two types of alignment that this section explores:

- Have HIV and AIDS been identified as an issue for horizontal alignment? If so, in what ways?
- Have HIV and AIDS been identified as an issue for alignment between the municipalities and other spheres of government? If so, in what ways?
- Do the strategic responses appear complementary or contradictory to those of the other spheres of government or relevant municipalities?

Given the all pervasive nature of HIV and AIDS matters, alignment with government institutions can only be a partial intervention. In addition, co-operation and co-ordination with a range of civil society, private sector and even customary authority role-players is required, as part of a broader partnership-driven approach.

Evidence of alignment is limited

Given the limited HIV and AIDS expertise and capacities in individual municipalities and the fact that the pandemic and its impacts are not administratively bounded, it is critical to consider whether municipalities within the same district are seeking to co-operate with one another to respond to the pandemic.

This approach was followed in the Ehlanzeni district where a district-led (but NGO-supported and international organisation-funded) in-depth study was undertaken and shared across all local municipalities in the district. Further, by involving two provincial sector departments, namely the health department and the education department, the district was able to establish a basis for vertical alignment, albeit a partial one. Presumably, there may be other departments which could have been involved, such as the welfare department. Nevertheless, this intervention bodes well for creating planning conditions that are supportive of alignment. By bringing together expertise on HIV and AIDS, the district was able to identify issues of relevance to most, if not all local municipalities.

This joint analysis approach is not restricted to HIV and AIDS issues but was also followed for other issues addressed in the IDP. Regrettably, the information generated in the course of the in-depth study was not interpreted by the local municipalities to reflect on how the district-wide findings apply to the local context. Instead, several municipalities merely copied the in-depth analysis findings into their own IDP. The local municipalities did not internalise this information to support future planning in the form of objectives, strategies and projects. This implies that alignment activities did not realise their full impact. Furthermore, the nature of the projects defined by the various municipalities in the district does not suggest that alignment activities took place in respect of HIV and AIDS strategies and projects. While not fundamentally contradictory, the various strategies and projects developed in the respective local municipalities appear to lack coherence with one another, and some even appear to duplicate interventions planned by the district municipality. Finally, while the strategic response of most municipalities in the district emphasises the necessity of establishing partnerships with civil society organisations, none explores the possibility of such partnerships being created with either private sector role-players or traditional authorities.

In the West Rand IDP, there is no evidence that HIV and AIDS were identified as an issue for alignment between the district and local municipalities, although most IDPs identify HIV and AIDS as a priority issue. The approaches to defining and exploring HIV and AIDS matters were not complementary. Some local municipalities focused on infection levels while others adopted a more open-ended approach. Typically, this would make considering the alignment potential of a given priority issue particularly difficult. Further, while some municipalities identified the policy framework applicable to HIV and AIDS matters, none applied themselves to defining the implications of the policy framework for their particular local context.

In some local municipality IDP, evidence of a mismatch between expected funding sources for HIV and AIDS projects and available sources was noted. In particular, one local municipality identified erroneously the Department of Provincial and Local Government as the funder for the development of an HIV and AIDS strategy. Overall, the lack of joint analysis activities is not specifically limited to HIV and AIDS issues but is symptomatic of the lack of alignment activities in respect of all priority issues. It is, however, true that not all IDPs considered in this research were reviewed IDPs, and that subsequent revisions to the IDP may see greater co-operation between the municipalities and the other spheres of government. Finally, partnership possibilities are not extensively considered by most IDPs. It appears odd that in spite of the substantial level of HIV- and AIDS-related activity of the mining houses located within the district area of jurisdiction there is no evidence of co-operation with this type of role-player in any IDP.

In Ethekwini, the extensive consultation drive of the planning process appears to have influenced the way in which HIV and AIDS matters are both defined and responded to. In fact, the partnership theme, articulated in relation to HIV and AIDS issues, underlies the responses developed to other priority issues. Yet, it would appear that much still needs to be done to move from the broad concept of partnership, be it in the form of planning and implementation alignment with other spheres of government or of engagement with non-government role-players, to practical action-orientated planning and implementation. Indeed, as is the case with all other matters addressed in this IDP, the specification of projects and activities has not been included in the planning document.

A common deficiency across all IDPs is the lack of evidence that alignment activities have been undertaken with adjacent municipalities. This is confirmed in terms of the process information contained in the IDPs which does not reveal that engagement with neighbouring district municipalities has occurred. The rationale for district-district alignment does not appear to have been considered by the district municipalities or the metropolitan municipality. Therefore the risks associated with the failure to co-ordinate and align the objectives, strategies and eventually projects developed in respect of common issues need to be unpacked. The absence of alignment presents major challenges for district municipalities and the local municipalities in their area of jurisdiction. Firstly, most districts have to draw on similar resources to implement their IDP projects. These resources are institutional, financial, natural and market-related.

By not engaging with one another on similar issues, the districts may have set themselves objectives, defined strategies and formulated projects that actually compete against one another to access these limited resources. Simply put, by not engaging with one another in order to prioritise access, the district municipalities may have given up their opportunity to influence investment and implementation by other organs of state in their respective area of jurisdiction. Secondly, by not engaging with one another as part of their planning process the municipalities have not been in a position to make use of limited resources in an efficient and effective manner, and may not have been able to consider alternative solutions to common problems. There are certain types of issues which cannot be affected by the actions of one municipality in isolation from the others. These issues transcend district boundaries. HIV and AIDS fall within this category of issue. By not engaging with neighbouring municipalities on such issues, objectives and strategies, the district municipalities have limited the effectiveness of their own IDP.

4. CONCLUSIONS

The previous section presented the detailed findings of the research. Although the research sample was limited, a certain set of conclusions can be reached about the manner in which municipalities identify, interpret and respond to HIV and AIDS in their IDPs. These conclusions can be summarised as follows.

Most municipalities identify HIV and AIDS as a risk and an issue which requires a strategic municipal response. This finding suggests that municipalities are neither unaware nor unresponsive to HIV and AIDS issues, and that they do not perceive such issues as pertaining to other spheres' competencies. While the primary lens for analysing HIV and AIDS remains focused on health matters, there is also evidence that the range of HIV and AIDS impacts on local development circumstances is being internalised in the IDP, in particular as part of IDP review activities. This implies that, even if it is primarily in terms of the interpretation of HIV and AIDS impacts, municipalities are beginning to articulate the human development face of the pandemic, thus breaking the sectoralised mould in which HIV and AIDS matters have been squeezed into at national and provincial level. This does not necessarily amount to successful mainstreaming of HIV and AIDS matters. In particular, there remains a lack of understanding that, like other cross-cutting dimensions, HIV and AIDS may affect sectors and the municipality's ability to govern.

Of concern is the gradual reduction in the facets of HIV and AIDS dealt with the IDP when moving into objectives, strategies and projects. The responses to HIV and AIDS matters are narrowed down to activities such as untargeted awareness campaigns and aligning with the activities already provided through health sector interventions within the national HIV and AIDS strategy. While one may argue that this tendency emerges in the face of municipal inexperience and lack of expertise to deal strategically and innovatively with HIV and AIDS matters, it is also clear that the tendency to append pre-determined uni-dimensional sector solutions to locally identified issues does not solely affect HIV and AIDS matters. Instead, it seems to be a systemic response to the current framework for intergovernmental fiscal relations, where nationally or provincially articulated and controlled programmes are the prevailing source for local project definition and implementation (Feldman and Ambert, 2003). In this context, given the limited scope of the national response to HIV and AIDS, it is almost inevitable that the type of HIV and AIDS projects that find their way into municipal IDPs should also be limited in scope. While some institutional capacity-building relating specifically to HIV and AIDS matters may enhance municipalities' ability to respond strategically to HIV and AIDS impacts on local development, it is also unlikely that it will fundamentally challenge the entrenched pattern of municipal dependency on pre-determined programmes to be implemented through nationally and provincially controlled conditional grants.

The issues emerging from the integrated sector programmes and plans are particularly challenging. Firstly, it is important to note that several municipalities have included an HIV/AIDS programme as part of their IDP, in spite of it not being a legal planning requirement. Secondly, none of the IDPs examined contains the full complement of sector plans, strategies and/or programmes required by sector law or even provided for in terms of the Municipal Systems Act. This finding implies that, in spite of suggestions that municipalities are not engaging with HIV and AIDS matters in their IDPs because it is not a legal requirement, the municipal ability to do so may be impervious to the imposition of statutory requirements to that effect. Instead, it would appear that a combination of factors enhance or undermine the likelihood of HIV and AIDS featuring in an IDP. Yet, including an issue as part of a process and its product does not guarantee that such issues will be adequately dealt with.

Similarly, in terms of vertical and horizontal alignment as part of a broader partnership approach, while legislation and policy emphasises the need for alignment to occur as part of the IDP, the extent to which it has adequately been addressed varies across IDPs.

For instance, at the most basic level, some reference is generally made to the national strategic plan. Yet, a much more constructive process of internalising strategic guidelines and information to suit the local context appears to be lacking, in respect of HIV and AIDS issues as well as other priority issues. This amounts to a superficial interpretation of the meaning of alignment, which does not necessarily comply with the substance of the legal requirement for alignment.

The above implies that while municipalities are attempting to grapple with HIV and AIDS issues, they are unable to do so strategically. Yet, there appears to be a correlation between the strength of the analysis of and responses to HIV and AIDS implications for municipal governance, and that pertaining to other development issues. In other words, where it is particularly sound or weak, the manner in which HIV and AIDS dimensions have been explored and responded to through participatory and technical means reflects the means of analysis and planning employed for other issues dealt with in the IDPs. This is a critical lesson, which implies that the ability of municipalities to engage with HIV and AIDS issues rests heavily on their capacity to mainstream other cross-cutting dimensions, such as gender or poverty. Appointing a high-ranking official to oversee integration of HIV and AIDS matters in the municipal line-functions or locating the institutional responsibility for such matters in the office of a prominent municipal official and/or politician (such as the municipal manager and/or executive mayor) may assist this process, provided that the officials in the other line-functions are able to engage with cross-cutting dimensions of development. In the short-term, co-opting external institutional resources and expertise to support the development of strategic responses to HIV and AIDS could assist municipalities with limited human resources. However, ensuring that the value of their respective contributions is not sectoralised will be contingent on the actual practice of IDP within a given municipality. There may be a range of support interventions required to strengthen municipalities' ability to engage with HIV and AIDS matters. Yet, developing greater familiarity among municipal role-players with the internal logic of IDP as a participatory, strategic, integrative and developmental planning process, will not only strengthen their ability to engage with HIV and AIDS matters but also other issues that are fundamentally relevant to the emergence of developmental local governance.

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